STATE TITLE V BLOCK GRANT NARRATIVE
STATE: VT
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

The required assurances and certifications are maintained on file in the Vermont Department of Health's central administrative offices. The information can be accessed by contacting Sally Kerschner, Vermont Department of Health, Division of Health Improvement, PO Box 70, Burlington, VT. 05402, 802-865-7707.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

Ongoing public input for Title V programs takes a variety of forms that allows direct Title V input and also input into general MCH programs. The public budget process is one opportunity, as the governor's budget is published in the newspaper and open to comment by various advocacy groups and members of the public. An annual legislative committee session is purposely advertised for public attendance to allow for input into Title V and other federal grant applications. Community Public Health conducts focus groups and surveys for the WIC and EPSDT programs to assess satisfaction with services and to solicit input for suggested improvements as well as additional services. The Office of Dental Health has conducted focus groups with low income consumers about access to/satisfaction/awareness of oral health care services. CSHN partners with parents (including parents of CSHCN who are not served or are not eligible for CSHN programs) through Parent to Parent and its facilitated focus groups, surveys and interviews. Through P2P, CSHCN hires parents as Children's SSI coordinators, providing outreach to Vt's families whose children are eligible for SSI. In addition, seven of the CSHCN clinical staff are parents of CSHCN. The Advisory Council for Vermont's CSHCN Medical Home grant also includes three parent representatives, one parent staff member, and two other "professional representatives" who are also parents of CSHN. Also, the CSHCN Family Advisory Council is composed of parents.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

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Vermont is a scenic and mountainous state, located in the New England (NW) region of the United States, sharing its northern border with Quebec, Canada. It is a rural state with the 2000 census showing a population of 608,827, ranked as 49th in population nationally. Population growth has been modest since 2000, with an estimated growth rate of 1.7%. Almost all Vermonters are identified as white, although this number decreased slightly over the past ten years - 96.8% in 2000 (vs. 98.6% in 1990). About 2% (14,273) of Vermonters identified themselves as biracial or multiracial and another one half of one percent (3,063) people said they were black. Although, nationally, Hispanics are rapidly growing in numbers as a group, in Vermont they make up only 0.9 % of the population. In addition, close to 1,000 Vermonters identified themselves as Vietnamese in 2000 (compared to 236 in 1990) and the Chinese population doubled to 1,330 during the decade of the 1990's.
The 2000 census revealed several expected trends in Vermont's age distribution. The median age of Vermont residents in 2000 was 37.7, up from 33 in 1990. The population group experiencing the largest increase was the 45-54 age group, with an increase from 10.2% (1990) to 15.4% (2000). The number of people aged 85 and older also increased, from 7,523 (1990) to 9,996 (2000). The number of children aged birth to 19 increased slightly to 166,257. However, those children under five years of age decreased, from 41,261 (1990) to 33,989 (2000).
Household composition is changing, also. The number of Vermonters living alone increased by 28% in the past decade, to 63,112. Also, there is an increase in the number of unmarried partners living together -- 18,079 (47%). The number of households with married couples living together fell to 52.5% of all Vermont households. Married couples with children younger than 18 (the traditional nuclear family) make up 23.2% of the households in Vermont, a statistic that mirrors national trends.
In 2000, there were 6,271 marriages (32% out of state residents) and 2,526 divorces. On July 1,2000, a new Vermont law went into effect granting same-sex couples in Vermont all the benefits, protections, and responsibilities under law as are granted to spouses in a marriage. From July - December, 1,704 civil unions were established in Vermont (78% being out-of-state).
Vermont was the second fastest growing New England state during the 1990's, as population increased by 8% according to the 2000 census. Of the 251 towns and cities in Vermont, only seven have total populations that exceed 10,000. Vermont's largest city is Burlington, with an estimated population for 2000 of 38,889. Vermont has 14 counties, and one metropolitan statistical area (MSA), the greater Burlington area. The estimated population of this MSA is 166,126, representing approximately 27% of the state's population.
Vermont's governmental structure consists of state government and town/city government, with essentially no county governmental structures, except for certain key services such as the court system. The bicameral legislature is considered a citizen legislature that is in session during January through May each year. During the Fall, 20004 election, a Republican governor was elected to his second term in office. The 2004 elections legislative elections created a Democratic majorities in both the stat House and Senate. Vermont has no county health departments, but is divided into twelve Agency of Human Services districts, each with a district office of the Vermont Department of Health headed by a District Director (Vermont's equivalent to a local health official). The recent government reorganization has created regional field offices of the state's human services offices, with which the VDH offices collaborate closely.
The number of jobs in Vermont declined in 2003 by 0.07%. This was the second consecutive annual decline and reflected the slow recovery from the 2001 recession. By 2004, the economy had improved and Vermont's job growth was close to its usual annual average of 2%. Vermont is the home to many long established businesses such as IBM and C&S wholesalers, but the economy is diversified with industries in manufacturing, tourism and services. Agriculture is still a vital part of the economy, but its importance has diminished over the several decades. Vermont's rural nature and areas of poverty presents the issue of sparse populations having ready access to resources and services. Residents living in isolated areas of the state may have special difficulties accessing

services and medical care (particularly in the harsh winter months) due to their remote locations and the less than optimal road conditions. Another challenge for the delivery of Title V services is the fact that a sizeable proportion of Vermonters are living either in poverty or are living very near the poverty level. Vermont's poverty rate was 10.1% for 1998-2000, which was 21st lowest among the states. The rate has not changed substantially over the last fifteen years. Of these families who live below the FPL, 24 percent are families with a female head of household. Approximately 1 in 7 Vermont children lives in poverty. Unemployment rates range from 1.8% for Chittenden County (Vermont's most populous county) to 5.9 percent in Orleans County (Vermont's second most rural county), resulting in a state average of 3.6 % (2000 census.) Five percent of Vermont's population has less than a 9th grade education; eight percent haven no high school diploma; thirty two percent have a high school diploma or equivalent and eighty-six percent have a high school diploma or higher (2000 census data.)

Using other measures of health status, the 2001 Family Health Insurance Survey conducted by the Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA), shows Vermont's uninsured rate as being 8.4%, while the rate for children is 4.2%. This makes Vermont as being among the top ten states with the lowest rates of uninsured in the nation (national rate of 14.3%.)

In other indicators, Vermont ranks first in the nation in the ratio of teachers to students in the public schools: 12.1 pupils to one teacher vs. a national ratio of 16:1. Vermont is sixth lowest in the rate of reports of child abuse and neglect: with a rate of 240 reports per 10,000 population aged birth-18 years vs national rate of 419 in 2001. Vermont has the second lowest rate nationally of violent crime. In 2002, Vermont's rate (the number of crimes known to police per 100,000 population) was less than one-fourth of the national average: 106 compared to 495 for the nation.

Since 1980, the Refugee Resettlement Program has relocated over 4,000 refugees to Vermont, increasing the cultural and linguistic diversity of the population being served by the health care and social service system of the state. Recently resettled refugees have arrived primarily from Vietnam and the Balkans, along with a rise in refugees from Africa. This population of new residents may have more difficulties in accessing the health care system and other services because of language barriers, cultural differences, and unfamiliarity with the American health care system and available health resources. In addition, there is a shortage of trained interpreters and translators. Addressing the needs of this group is another challenge in the delivery of Title V services.

In examining coverage by providers of health care services, analyses show a generally acceptable ratio of physicians to population. However disparities by geography affect access to health care. Thus, even the loss of one provider can be significant for the special populations (such as MCH) living in the rural areas. Statewide, there are 32 primary care pediatric practices with 113 practicing pediatricians. This is approximately 80.9 full time equivalents, indicating a higher coverage for Vermont statewide as compared to the recommended 63.2 for Vermont's population size (GMENAC recommends 10.7/100,000 population.) However, marked disparities are revealed by analysis of FTE coverage within the state, revealing 8 out of 14 Health Care areas have inadequate or severe shortage of pediatric coverage. In addition, there are 51.8 FTE's of OB/GYN providers statewide, yet two counties have no OB/GYN providers, six have only two, and the remaining OB/GYN's practice in six counties. The same issue is evident with dental providers: Vermont's overall provider to population ratio of 1/2,564 for primary care dentists is similar to the national average, however several counties have either a short supply of dentists and specialists or have a large number of dentists approaching retirement age. The Office of Rural and Primary Care is tracking these trends and supporting activities to recruit new providers to the state. For further discussion see Section 4.1 of Strengths and Needs Assessment (SNA.)

Vermont is experiencing a professional nursing shortage, as is the rest of the nation. A survey of 6,008 nurses in 2001, indicated the median age for nurses is 46 years, with 75% being over 40 years old. The average number of years working as an RN is fourteen. Forty percent of those surveyed, who report working in Vermont, work in a hospital setting. Twenty-one percent indicated that they are "somewhat" or "very" likely to leave their primary position in the next twelve months. Of these nurses, 27% said they would leave because of job dissatisfaction and 28% because of salary dissatisfaction. The VDH, in conjunction with a broad based statewide coalition and the University of Vermont (UVM), is working on a variety of recruitment and retention strategies for the increasing the capacity of the nursing workforce in Vermont. Early successes are indicated by UVM's 17% increased enrollment of

nursing students in August, 2001 and a 74% increase in first-time, first-year applications as if February, 2002.

Vermont Health Care System of Publicly Funded Insurance

In July of 1995, Vermont's Medicaid 1115 Research and Demonstration Waiver application to create and implement the Vermont Health Access Plan (VHAP) was approved. The waiver allowed for a basic package of insurance coverage for previously uninsured adults with incomes up to 150 percent of the federal poverty level (FPL). In February, 1999, eligibility for previously uninsured adults was expanded to include parents and caretaker relatives of Medicaid-eligible children up to 185% FPL. The waiver also allowed for mandatory enrollment into a managed care plan for nearly all Vermonters who have Medicaid/Dr. Dynasaur (the name for children's Medicaid) insurance as their sole source of health insurance. Individuals with another source of insurance, or who are recipients of Medicaid Home and Community-Based Waiver Services, or who are in the Medicaid Hi-Tech program, remain covered by the Medicaid FFS model. The 1115 Waiver was implemented as of January 1, 1996. Enrollment into managed care plans began on October 1, 1996 for Medicaid families, children, and newly insured VHAP enrollees. One managed care plan, Kaiser Permanente/Community Health Plan/Access Plus, participated at the outset, and a second, Blue Cross/Blue Shield BlueFirst, joined as of January 1, 1997. However, in April, 2000, Kaiser Permanente left the Northeastern market and Blue Cross Blue Shield, in mutual agreement with the Office of Vermont Health Access, terminated the BlueFirst program. PC Plus was therefore expanded to accommodate the additional beneficiaries. As of June, 2003, approximately 85,000 people were enrolled in PC Plus. The latest Health Insurance survey indicates that an estimated 95.8% of Vermont children have health insurance.

Vermont is fortunate in that virtually all medical doctors in the state accept Medicaid insurance. The latest health insurance survey data indicated that an estimated 95.8% of Vermont's children have health insurance. In October 1998, the children's Medicaid program, Dr. Dynasaur, expanded eligibility for children birth to 18 years to include those with incomes up to 300% FPL, further reducing the percentage of Vermont children who are uninsured. (Vermont had been covering children with incomes up to 225% FPL since the early 1990's.)

The MCH Director, the CSHCN Director, and other key MCH staff continue to be involved in the administration of the Medicaid program. For example, through EPSDT, the MCH Director, the Director of the Division of Community Public Health, and other key program managers continue to assure that children and youth have access to quality health care through the dissemination and updating of the Vermont-specific pediatric periodicity schedule and the provider toolkit that accompanies it. The VDH managers work very effectively and collaboratively with Vermont AAP and AAFP to continuously review, develop, and distribute best practices for pediatric care. Also, the EPSDT program has enhanced its system of regular contact with Medicaid families to inform them of their child's health needs within the pediatric periodicity schedule.

In Vermont, individuals with disability-based SSI are also eligible for Medicaid. A study group examined strategies for enrolling SSI recipients in the managed care plans. After a brief pilot in two counties, it was determined that the best form of managed care for these individuals would not be a pre-paid HMO model, but rather a primary care/case management model (PCCM). This PCCM program, called Primary Care (PC) Plus, began in October, 1999.

The Child Health Insurance Program (Title XXI)

Vermont's application for the Child Health Insurance Program (CHIP) has been approved with modifications to its original application. Children who have no other insurance coverage are enrolled in PC Plus and are eligible for the Title XXI enhanced federal match rate. This group of approximately 3,100 children comprises the Vermont CHIP enrollment. Children who have another form of insurance are not eligible for CHIP, but continue to be eligible for the expanded Medicaid/Dr. Dynasaur program described above. These under-insured children are enrolled with Medicaid as a secondary payer of last resort, after insurance (or commercial HMO), on a fee-for-service basis. Vermont is engaging in strategies to promote enrollment and utilization in these expanded insurance opportunities for children, such as conducting an oral health public education campaign and sending informing letters

to families who use Medicaid. The FFY 2004 Vermont state budget included a provision to implement a premium assistance program for SCHIP beneficiaries whose families have access to employer sponsored insurance. Prior to implementation, the commissioner must report to legislative committees regarding the cost-effectiveness of the initiative, including the cost of administering the program compared to potential savings. Vermont's comprehensive health care programs for children can offer nearly universal coverage for families. In the state legislative session of 2005, more efforts were made to expand coverage to a universal, state funded system of health care. The proposed legislation did not pass, but a legislative committee was created to examine possible solution for Vermont in the financing of universal coverage for its citizens.

Current Priorities
(See also Section IV for discussion of the MCH 10 Priority Needs and the national/state performance measures.)

The "Vermont Blueprint for Health" is a venture initiated by the governor, which is dedicated to achieving a new health system for Vermont. The Blueprint is several things: it is the vision that health care can be made better for Vermonters; it is a plan that provides the structure and outcomes to achieve that vision; and it is a partnership of organizations, public and private, that are committed to its implementation. The goals are 1) To implement a statewide system of care that enables Vermonters with, and at risk of, chronic disease to lead healthier lives. 2) To develop a system of care that is financially sustainable, and 3) To forge a public-private partnership to develop and sustain the new system of care. The framework for change is based on the Chronic Care Model. As its ultimate goal, the Model envisions an informed activated patient interacting with a prepared, proactive practice team, resulting in high quality encounters and improved health outcomes. It has six components: community, health system, decision support, delivery system design, self management education and clinical information systems. Intense planning for implementing the Blue print began in 2004 -- presently two Vermont communities are piloting key components of the Blueprint.

Vermont continues to prioritize the strengthening of community based and statewide systems to support families' access to quality and affordable health care, including those with children with special health care needs. Vermont is considered exemplary in its successes in providing health insurance for its citizens. Presently, over 92% of Vermont residents have some form of health insurance, with 96% of infants, children and adolescents being covered. However, efforts continue to address families who may have some form of insurance but who are under-insured. Vermont has received a Robert Wood Johnson grant (Covering Kids) to develop and provide enrollment outreach to such families. Another area in need of attention is the utilization of health care among school-age children and adolescents; the School EPSDT Health Access Program is engaged in efforts to address this issue, along with coordination efforts with the Department of Education. Dental health care access is a longstanding problem for Vermonters and one that the Department of Health is addressing through the activities of the Dental Health Unit, MCH, and the Office of Primary Health Care. In 2004-2005, a statewide advisory committee created an Oral Health Plan containing such strategies as outreach to families via schools and other services, increasing dental care reimbursement rates, increasing the number of towns with fluoridated water systems, and increasing data tracking abilities via linkages with Medicaid.

Although Vermont has made significant progress in lead poisoning screening, there continues to be room for improvement. In 2000, the Commissioner of Health issued revised screening guidelines that recommended universal testing of 1 and 2 year old children. VDH is undertaking efforts to increase lead testing of children and promote the Vermont Lead Law that requires maintenance practices in rental properties and childcare facilities (see Section IIIB and Strengths and Needs Assessment.)

The mental health needs of children and families are also of special concern and receive attention across a number of agencies within the Agency of Human Services. One focal point for activities related to children's mental health is the Children's UPstream Services (CUPS) grant, a 5-year project to support and preserve families of young children who are at risk for experiencing severe emotional disturbance (SED). Also, Community Public Health is working with the Vermont Child Health

Improvement Program (VCHIP) to implement tools for screening for depression in youth in well child checks. Opportunities to increase the effectiveness of this collaboration are being created from the reorganization of the Agency of Human Services (began in 2003) resulting in the Department of Mental Health combining with the Department of Health (see discussion IIIC Organizational Structure.)

Healthy Babies, Kids and Families (HBKF) uses a system of care approach to coordinate services for Medicaid eligible pregnant women, infants, and children up to age 6 years. The program is managed by MCH nurse coordinators in each of the 12 health districts through the cooperative efforts of local Maternal and Child Health Coalitions. Within each health district, the Department of Health provides the primary administrative functions, including: formal enrollment of women and infants into the program; determination of the level of service for which the individual is eligible and prior authorization, based on medical and psychosocial needs; referral to appropriate community resources; data collection; reports of aggregate information; program evaluation; and oversight of standards for service providers. The program was initiated in four health districts in 1994 and has been operating statewide since February 1997. Pregnant and postpartum women are referred to this program through local medical providers, community service agencies, WIC clinics, EPSDT outreach, school nurses, the statewide toll-free Help Your Baby, Help Yourself hot line, and self referrals. The prenatal component of this program focuses on all eligible pregnant women, with particular emphasis on women identified at high risk for a low birth weight delivery (e.g., history of premature labor, multi-gestation, late entry into prenatal care). The program provides periodic home visits or group encounters that include screening, assessment, health education, counseling and risk reduction education, assurance of access to care, and case management services. Medicaid reimburses for home visits by MCH nurses and family support workers and perinatal group education for pregnant and postpartum women. Home visits, group encounters, and telephone contacts are continued through the postpartum period. Hospital discharge planning is guided by the Maternal Postpartum and/or Newborn Follow-up Algorithm. Examples of specific activities include offering home visits during the weekend and evening hours and the development of services for fathers, such as the national "Boot Camp" program. Special priority is given to pregnant and parenting teens. Priority for HBKF services is also given to infants birth to 12 months of age and high risk children ages 1-5. Activities include ensuring regular primary care, screenings and immunizations; assessment and referral for identified concerns of the parent or provider, and connections to community resources. In 2002, funding from National Academy of State Health Policy (NASHP) enabled participation in the national Assuring Better Child Development (ABCD) Consortium and supported this expansion of HBKF to include children up to age six. In 2004, the Agency of Human Services reorganization resulted in the transference of HBKF from the Health Department to the newly formed Department of Children and Families. This organizational transfer is to streamline service delivery for AHS clients (See Section III. C. for information on program activities.)

Nearly ten years ago, the VDH in coordination with providers, schools, insurers, and others, developed a model Health Screening Recommendations for Children and Adolescents, also known as the Vermont Periodicity Schedule. Although the federal law requires that the VDH EPSDT program determine the scope of services for children using Medicaid, Vermont developed this well child screening instrument for all children, regardless of insurance payor. The Vermont EPSDT periodicity schedule has been important in the effort to promote new approaches to child and adolescent health supervision, consistent with the current emphasis on health promotion and the prevention of psychosocial morbidity. A clinical providers' tool kit has been developed and distributed which contains screening tools and incorporating information related to the EPSDT periodicity schedule. The tool kit continues to be distributed to pediatricians, nurse practitioners, family practice physicians, and school nurses. Ongoing efforts are being directed toward systems development with regard to the implementation of these standards of practice. A committee of VDH staff, health care providers, and QI experts continuously update the clinical guidelines and the providers' toolkit. Planning is underway for an obstetric clinical guidelines/periodicity schedule.

VDH continues to be active in many broad systems issues that influence maternal and child health. In light of welfare reform, day care quality, affordability, and availability has become an even greater

priority. VDH is involved in the planning and programming for Healthy Child Care Vermont, now folded in to the ECCS grants, which provides technical assistance to child care providers about key health and safety issues (see in-depth discussion below.) Also, the Division of Community Public Health participates in a state advisory committee on welfare reform. The welfare reform advisory committee continues to focus on child care and transitional child care for parents receiving ANFC, the draft policy that exempts women who are trying to escape family violence from the work requirements under welfare reform, and ANFC parents' transportation needs relating to employment or training.

The Department of Health has become increasingly concerned about the high rates of marijuana and alcohol use among adolescents in Vermont, and the state has a federal grant from the Center for Substance Abuse Prevention that provides funding for research-based community programs to prevent alcohol and drug use among Vermont youth. In addition, a growing concern about the use of illegal drugs such as heroin and cocaine has focused new planning and community based efforts. In 2003, a methadone clinic (associated with Fletcher Allen Health Care) was established in Vermont -- planning for one more clinic is beginning. Beginning research and assessment has begun on the issue of prenatal alcohol consumption and the resultant effects on the fetus - funding for development is being researched at present.

The Vermont Department of Health divisions of Community Public Health (CPH) and the Alcohol and Drug Abuse Programs (ADAP) are responding to a growing maternal child health concern regarding high risk chemically addicted pregnant and parenting women. As the client is identified, she may be referred to Fletcher Allen Health Care/University of Vermont's Comprehensive Obstetrical Service (COS) for prenatal care including screening, nutrition, and referrals to substance abuse treatment. Consultation with a neonatologist occurs at 28 weeks EGA. COS has become a model and resource for this population around the state. By joining efforts, these divisions and many community partners such as mental health, child welfare, hospitals, home health agencies, pediatric and obstetrical practices, corrections and substance abuse providers are developing a state wide system of care for these mothers, children, and families. ADAP and CPH are working to support communities in the development of community based response teams. These teams are being modeled after the Healthy Babies Kids and Families community steering committees and use a child protection empanelment process to protect family confidentiality. Several public health district offices have taken the lead in their communities with this effort. Goals for this year include the development of community response teams in all districts, design protocol implementation teams to work with the Central Office and district offices to develop curriculums, identify barriers and train on location as needed, hold ongoing conference calls/meetings with districts to identify services barriers, foster communication and support and make recommendations for service delivery and system change.

New initiatives are being planned to not only combat obesity and promote physical fitness in all ages, but also to increase food security for children and their families. In the fall of 2003, Vermont's governor requested that the Department of Education and the Department of Health collaborate to develop strategies to counteract the problem of increasing incidence of overweight among children and youth. The result was a proposal for the Fit and Healthy Kids initiative. Key strategies were selected for implementation and funding for staff was allocated in the state budget for SFY 2005. Funding will also increase the number of Run Girl Run sites to 23, serving over 450 girls (Run Girl Run is a year round program designed to give middle school girls the information, training, confidence and support to make healthy lifestyle choices) and expand the Fit WIC program to include non-WIC families. (Fit WIC encourages physical activity in preschool children by providing parents and child care providers with age-appropriate games and activities designed to promote exercise.) In addition, in July, 2004, Vermont received CDC funding for the grant program, Nutrition and Physical Activity Programs for Prevention and Control of Obesity and Related Chronic Diseases. A steering committee will assist in creating a comprehensive state plan for the prevention of obesity and other chronic diseases. The plan will include strategies for integration with WIC, Comprehensive School Health, and the Department of Education as well as other programs working with children and adolescents. Strategies identified will be used to create effective interventions to increase healthy behaviors among all Vermonters, including children, youth and their caregivers. Local coordination between District Offices (WIC) and food shelves and other services aims to reduce prevalence of food insecurity. In

addition, the newly released draft of the Obesity Burden Document describes the issue of women of childbearing age who are overweight or obese. Of the women who delivered in 2003, 26% were obese and 13% were overweight. Planning has just begun to address this issue - see also Title V Strengths and Needs Assessment..

In other priorities, the Vermont Injury Prevention Plan, produced by the Injury Prevention Coalition, contains action steps designed to reduce the incidence in the MCH population of the following: suicide and suicide attempts, child abuse, drinking and driving, the prevalence of driving/riding without use of safety belt, fire injuries and deaths, and work related injuries. The Injury Prevention Program is also working on an implementation grant focusing on the issues of domestic violence and the development of clinical guidelines for health care providers for the identification, treatment, and referral of women who are experience inter-partner violence. A parent education pamphlet about infant safe-sleep environment has bee created and is now being distributed to medical practices and child care facilities. In addition, the VDH is developing strategies to strengthen the capacities of the Office of Women's Health, which now oversees programs supporting breast and cervical cancer screening, referral and clinical systems. The Title V planner works closely with OWH to coordinate on women's health issues. New planning is focusing on the health needs and reproductive health needs of incarcerated women. In the Tobacco Control Work Plan (issued June, 2001), the VDH put forth a ambitious plan with detailed strategies aimed at reducing smoking rates by half in all segments of Vermont's population. Particular attention is given to the high rate of smoking among pregnant women. The Diabetes Control Program is updating the publication, Diabetes Prevention and Control, with recommendations and guidelines for management within the school setting in order to inform elementary and secondary school personnel. Also, the Pediatric Periodicity Schedule has been updated to include screening guidelines for type-2 diabetes and pre-diabetes in overweight children.

Environmental health issues that are of special concern for children's health continue to be a focus of attention for assessment and planning. Collaboration continues between the Divisions of Community Public Health and Health Protection's Environmental Risk Assessment Unit in the ongoing specialized training of local environmental designee public health nurses. Over this past year, much of these nurses' time and energy has been focused on the local implementation of activities to protect the public against acts of terrorism (biological, chemical, etc.) Vermont receives funding for continuation of the cooperative agreement with CDC to upgrade state and local jurisdictions' preparedness for and response to bioterrrorism, other outbreaks of infectious disease, and other public health threats and emergencies. Grant year 2002-2003 focused on assessing the capacity of the health department in the context of the greater community, planning and beginning to build the critical infrastructure for preparedness using an all hazards approach. Particular progress has been made in communication and information systems, laboratory capacity, and epidemiology and surveillance. Relationships have been built throughout the state between the VDH Local Health Offices and schools to broaden surveillance capacity in the school arena. We are using forms/systems designed for chickenpox reporting as a way of assuring that the dialogues are ongoing. We now are receiving reports from 80% of all schools in the state. As a small state, we have a close relationship between VDH Central, the local offices, and other state and local agencies, professional and voluntary organizations, hospitals, and the National Guard. We are also developing cross border collaborations. Local action planning which includes plans for the needs of the MCH population, is happening via the Local Emergency Planning Committees (LEPC). The VDH District Offices are a major participants in these groups. In 2003, VDH participated in the national preparedness campaign related to smallpox. Vermont vaccinated 130 civilian health care workers, all adults and all of whom had been previously vaccinated, equating to 2% of the total population. There were no significant adverse events. As of 12/03, all PHN's were trained in smallpox vaccination techniques. Also, chemical and biological agent identification capacity has been added to the Department of Health State Laboratory. A three day emergency response training was held in August, 2004, designed using the Incident Command System for Public Health. The exercise was held in two of the twelve VDH districts and efforts are being made to address the special issues of emergency response for women and children. All District Offices have a disaster plan in place. Planning and preparation have been ongoing to address special populations in potential public emergencies. Beginning plans to vaccinate, prophylax, and care for those who have special needs or other barriers to care include accommodations for non-English

speakers, homebound persons, children and elderly populations, and those with mental illnesses. In the coming year of the newly funded five year cycle, Vermont will continue to refine its preparedness systems by developing criteria to indicate level of readiness, continuing to conduct and evaluate preparedness exercises, and developing a full continuum of readiness involving the communities and the entire state.

Infant mortality reduction and improving birth outcomes continues to be a high priority for the Health Department. The infant mortality rate in Vermont for 2003 is 5/1,000 live births, the lowest rate ever reported in Vermont. However, our MCH surveillance reports indicate that the rates overall, tend to not be significantly different year to year. However, surveillance continues to monitor these rates that, although low, may be slightly increasing and the two leading indicators related to infant mortality, low birthweight and preterm delivery, are increasing (see discussion in Strengths and Needs Assessment.) These data will be monitored by the VDH in order to guide strategic interventions. VDH continues to focus on the prevention of preterm deliveries and identification of psychosocial risk factors that put women at risk for preterm delivery. In 2002, the legislatively mandated Birth Information Council was formed under the direction of the Commissioner of Health. The broad based membership of the committee recommended the creation of a Birth Information System to enhance Vermont's ability to identify and refer to services appropriate newborns with special medical conditions. This strategy was approved by the state legislature and CDC funding is being used to support the position of a Birth Information System Coordinator who is planning for the implementation of the Birth Information System. Efforts at increasing surveillance of infant and child death and injury are getting a boost from the new system of enhanced hospital emergency department data in addition to the hospital discharge data. The MCH Planner, the Injury Prevention Coordinator, and the Office of the Chief Medical Examiner are beginning to collaborate on improved data collection methods from infant/child death certificates. The MCH Planner, surveillance staff, and the Injury Prevention Coordinator (along with representatives from the Child Fatality Review Committee) are working on the national pilot to develop a web-based Child Death Review data gathering system.

Other planning initiatives include the Early Childhood Comprehensive Systems Initiative (ECCS) grant planning activities. The ECCS funds are supporting the Health Committee of Building Bright Futures, Vermont's Alliance for Children. The goal of BBF is to develop cross-service systems integration partnerships in support of children in early childhood to enhance their ability to enter school healthy and ready to learn. This grant will assist the state and local communities in efforts to build early childhood service systems that address critical MCH components of access and medical homes, social emotional development of young children, early care and education, parenting education and family support. Vermont is in the second year of planning for development of a unified system of early care, health and education. This work corresponds well with other initiatives that have been underway in the state over the last two years, including a TA grant from North Carolina's Smart Start and also the AHS reorganization.

Additionally, in the Fall of 2002, the VDH was awarded an infrastructure and expanded health education grant from CDC. Planning is accomplished via newly hired coordinators and the statewide School Health Coalition working toward coordinated school health services, programs, and policies in schools. In addition, the School Health Coordinating Council, comprised of DOE and VDH decision makers, and also representatives of the School Principals' Association, Vermont School Boards' Association, and the Vermont School Superintendents' Association, meets monthly to coordinate statewide health related activities and policies for school aged children. The recently formed Linking and Learning newsletter, from a partnership with the VDH, Department of Education, an the American Cancer Society, highlights local and statewide programs on obesity prevention, physical activity promotion, HIV prevention, and tobacco use prevention.

The Office of Minority Health is supporting the operationalizing of the Department of Health's resolution to eliminate racial and ethnic disparities. In addition, the OMH is facilitating the development of strategies and recommendations from the Minority Advisory Committees and the Physicians Healthcare Survey. Also, OMH is supporting community-based trainings for health care professionals in the delivery of culturally competent health care. In the year 2005, the OMH began

strategic planning process for enhancing the cultural competency of health care practitioners and AHS employees. The MCH/Title V planner and other MCH staff in VDH are participating in this planning and will collaborate on implementing the resulting strategies.

After the AHS reorganization, the CSHN director is now a participant in the interagency/consumer committee reviewing home care programs now clustered in the new Department of Disabilities, Aging, and Independent Living; these include Medicaid Personal Care Services, High-tech program, and the Medicaid Home and Community Based Services Waiver for Developmental Services (all of these programs are Medicaid-funded). The focus is on improving the PCS application process for children and maintaining supports in a year of severe budget cuts in Medicaid.

Vermont Department of Health Planning Initiatives (See also III E - State Agency Coordination)

Vermont Health Plan: A Call to Action was released at a press conference on June 15, 1999. In keeping with the enabling legislation, this plan is intended to "…set[s] forth the goals and values of the state." The document examines health issues in five broad categories: human biology, habits and behaviors, the environment, economics and social factors, and health care. Issues and needed actions that are critical to the health of mothers, children and families are incorporated throughout the document. The first edition of the Annual Action Plan was released in the Spring of 2000. This comprehensive document draws on the Title V plan and other documents to identify strategies for addressing these issues.

The Health Department completed work on Healthy Vermonters 2010 through the selection and prioritization of objectives found in the draft document, Healthy People 2010 Objectives. This process will allow Vermont to focus attention on those national objectives that are of greatest concern for its citizens. The national objectives for Maternal, Infant and Child Health and Family Planning have been adapted for Vermont's specific public health needs. This process was completed in the year 2000, released in 2001, and the selected objectives and related strategies will be coordinated with the planning efforts described in Title V and the Annual Action Plan. Planning activities have also been coordinated with the Health Status Report, released in June, 2002. Other status reports deal with Men's Health and Women's Health. A woman's reproductive health needs assessment is being finalized in the spring of 2004.

For FFY 2006, the Title V Strengths and Needs Assessment was performed and the report is submitted with the Title V FFY06 application. New sources of qualitative and quantitative data that have been developed over the years (via SSDI and other initiatives) has informed the assessment. An approach of assessing both the strengths and needs of Vermont's MCH population has been used. Region 1 has collaborated on this overall approach of assessing strengths and needs of a population and on choosing appropriate common measures.

B. AGENCY CAPACITY

Preventive and Primary Care Services for Pregnant Women, Mothers, and Infants:
Prenatal and Postnatal Program: The Healthy Babies, Kids and Families System of Care is an enhanced, comprehensive, family-centered public health program for pregnant and postpartum women and infants up to five years who receive Medicaid. (For clients not on Medicaid and in need of these services, Title V provides payment.) HBKF is designed as a coalition among obstetrical and pediatric health care providers, public health and home health nurses, Parent Child Centers, and participating families. Case management, counseling and health education, risk reduction intervention, home-based care, group education and other supportive services are bundled together into one package tailored to meet the individual's health needs. See Overview.

Addison County Parent Child Center - Prevention of Teen Pregnancy Program - supported by Title V funds - provides outreach and prevention services to Addison County pregnant teens, young parents, and their families. Support groups are provided to both male and female teens and preteens who are considered at high risk of pregnancy, and pregnancy prevention education is provided at the local junior high and high schools. The "Dads" program, which is supported by Title X funding, works with young and expectant fathers to develop effective parenting skills. Close ongoing collaboration with HBKF.

Sudden Infant Death Syndrome (SIDS) and Sudden Unexplained Death in Infancy (SUDI) is undergoing a review of program protocols and goals. Goals are: 1) To reduce the impact of unexpected infant death on Vermonters via public education about infant care practices, 2) Assure system of care for families that provides compassionate investigation and appropriate grief services.

Comprehensive Obstetrical Services Program is administered by the Department of Obstetrics and Gynecology at Fletcher Allen Health Care in Burlington, provides comprehensive, team based, maternity care to women who are socially/economically at-risk. Clients statewide are eligible, but primarily live in the NE section of the state. The care coordination team includes an obstetrician, a social worker, a nurse and a nutritionist. Services include comprehensive prenatal care, lab and genetic testing, birth and postpartum services, enrollment in WIC, breastfeeding support, and contraception counseling. Service coordination also happens with the NICU and the intensive services for women who have chemical addictions.

Family Planning Program provides medical services, including physical exams, screening for cancer and sexually transmitted diseases, contraceptive methods and pregnancy testing; education and counseling about reproductive health, breast self-exam, STD/HIV risk reduction, pregnancy and infertility; and community education programs such as mother-daughter seminars, school-based education and professional seminars. Services are provided via funds contracted to Planned Parenthood of Northern New England (PPNNE), and are offered at 12 PPNNE sites statewide. Funded by: Federal Title X, Social Service Block grant, State general funds, Medicaid and private insurance reimbursement. All services are available on a sliding fee schedule for those with incomes up to 250% FPL; no one is turned away because of inability to pay. Services are targeted to women of child bearing age, particularly those of low income and under age 25. Services to men are available, and young men are encouraged to participate in counseling and education with their partners. Special funding from the Office of Population Affairs is supporting an outreach/education program for men -- at www.themanphone.org. The Man Phone program supports a variety of strategies for educating men ages 18-22 such as: hiring of two male outreach workers, ongoing updates to website containing reproductive information for young men, information placed on date service websites, public media campaigns. In addition, a collaboration between VDH and PPNNE has been expanded and strengthened to take action on certain findings in the 2003 Vermont Family Planning Needs Assessment, such as reproductive health needs of refugees and women in correctional facilities.

Pediatric Genetic Services are provided through a VDH contract with Children's Health Care Service at Fletcher Allen Health Care, which operates the Vermont Regional Genetics Center. Services include genetic counseling to families, evaluation, diagnosis, and treatment of genetic conditions; public information programs about teratogens, a pregnancy risk information toll-free hotline; and extensive technical assistance and consultation to VDH. For example, the Geneticist provided extensive TA to the Birth Information Council and to the metabolic/NBS programs. Services are available statewide. Special "travel clinics" are provided to insure statewide coverage. Services are funded by Title V, including federal, state match, and state overmatch dollars, as well as patient fees (however, individuals are served regardless of ability to pay. The pediatric geneticist continues to participate in the CSHN Metabolic Clinic and Newborn Screening Program and recently began participating in the CSHN Craniofacial program. She also provides extensive consultation to the Birth Information Council.

Newborn Screening Program provides for the genetic screening of occurrent births via legislation adopted in 1996 requiring screening for the following: phenylketonuria, galactosemia, homocystinuria,

maple syrup urine disease, hypothyroidism, hemoglobinopathies, and biotinidase deficiency./2005/ NBS panel now upgraded via legislation to include 14 additional conditions. The fee has increased from $27.50 to $33.30. Vermont uses the New England Newborn Screening Laboratory at U Mass for processing specimens. See NPM 1.

Perinatal Program at the University of Vermont is partially funded by Title V and provides professional education, transport conferences, and statistical analysis for individual hospitals and providers who treat medically high-risk pregnant women and neonates. Close collaboration with many statewide initiatives, such as the Infant Mortality Committee, the Birth Information Council, and QI efforts with birth hospitals.

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is a nutrition and education program benefiting infants, children under age five, and pregnant, postpartum and breastfeeding women with low-to-moderate income levels. WIC provides health and nutrition screening and referrals, nutrition counseling, and education. Via contracts with local vendors, WIC provides home delivery of selected foods tailored to individual and risk factors. Group nutrition education is offered at least twice during the client's certification period. Individuals with specific nutrition-related concerns receive additional personalized counseling from public health nutritionists. Programs such as the EPSDT Program, Immunizations, Healthy Babies, Kids and Families, and the Childhood Lead Poisoning Prevention Program are integrated or coordinated with WIC. VDH uses a joint WIC/Medicaid application form that automatically assesses and identifies Medicaid eligible clients to expedite Medicaid enrollment.

Office of Women's Health's goals include improving the health status of women, assuring access to high quality, comprehensive and coordinated health services, promoting healthier lifestyles and improving public policies that affect women's health. Long term planning (as capacity allows) will center around working with PPNNE on needs assessment, development of services for women in correctional facilities and outreach to refugee women. The WISEWOMAN program works to improve access to preventative health screening services, including screenings for blood pressure and cholesterol, and health education for uninsured women 40-64 years of age and participating in the National Early Breast and Cervical Cancer Early Detection Program.

Office of Minority Health (OMH) supports VDH programs to become culturally competent in programming and staff training. Past support activities: development of the Alcohol and Drug Abuse Program's Rite of Passage Initiative, the implementation of a DHHS-OMH grant to address disparities in cancer, diabetes, and heart disease within the Lao and American Indian communities through the strengthening of intergenerational relationships, and the increase of tobacco cessation and prevention program activities within the minority and GLBTQ populations. The VOMH is a member of the Interpreter Task Force that coordinates training opportunities for Vermont non-English language interpreters and translators.

Preventive and Primary Care Services for Children:

Immunization Program - See NPM 7 and the Strengths and Needs Assessment. Vaccine Purchase and Distribution Program's goal is to strive for the elimination of all vaccine preventable diseases. The program purchases vaccines, conducts assessment of immunization coverage, conducts surveillance of vaccine preventable disease, assists in outbreak control, provides education and TA for clinical providers and the public, and develops policies and plans that support immunization strategies and evaluate effectiveness and QA activities. The vaccines purchased by this program are provided without charge to physicians who participate in the Vaccines for Children program. In addition to the actual provision of the vaccine, the Immunization Program assures that the vaccines are appropriately allocated and available to providers, shipped, stored, and handled according to guidelines and made available to individuals for whom they are indicated. The VFC Program has 532 providers enrolled at 177 sites statewide. To date, 120 sites have been visited to assess vaccine storage and to assure that every dose of vaccine is fully viable, documented correctly, and administered to a VFC-eligible child. The Assessment, Feedback, Incentives and Exchange (AFIX) Program has evaluated

immunization coverage rates for 19-35 month olds in 103 private provider sites in partnership with the Vermont Child Health Improvement Program (VCHIP) to identify barriers to full immunization of children in their practices with the goal of reduction or elimination of barriers.

Childhood Immunization Registry tracks eligibility for the VFC program while recording immunizations as well as their contraindications and objections as voiced by parents. Birth data is entered automatically within ten days via the Vital Births data system. Currently all children born in Vermont since January 1, 2000 have demographic information entered. Forty-six practices are enrolled with 43,412 children in the registry and13,105 have two or more immunizations recorded. The registry is expected to result in higher immunization levels, generate all legal immunization records and corresponding documents for child care operators and school personnel, and provide easier assessment of current immunization status by health care providers. These efforts will decrease missed opportunities to bring children up to date with their immunizations. Also, the fully functional statewide immunization registry will include a reminder/recall system to keep children up to date with the recommended immunization schedule. All of the core data elements recommended by the National Immunization Program and approved by the National Vaccine Advisory Committee will be recorded electronically.

Childhood Lead Poisoning Prevention Program (CLPPP) provides free blood lead screening (via capillary technique) for children at WIC clinics located in the 12 VDH district offices and PHN's offer TA and training for providers to incorporate this screening within their practices. The VDH coordinates with Vermont Chapter of the American Academy of Pediatrics to promote office based blood lead screening as being done in the private sector. CLPPP provides an environmental assessment of a child's home and day care if the child is severely poisoned (> 20 micrograms/deciliter) or has persistent levels of 15-19 micrograms/deciliter. In owner-occupied housing, VDH works with parents to develop a plan to make their home safe. In rental properties, VDH (via HUD grant) works with the property owner to implement a lead hazard reduction plan. The Vermont Housing and Conservation Board can assist owners with finances and project management. The State of Vermont in 1994 enacted legislation requiring that the VDH implement regulations to certify and train lead abatement contractors in the state. The VDH has funding from the Environmental Protection Agency for its lead abatement licensing and compliance activities. CLPPP conducts education campaigns and training programs for rental property associations, state agencies, Headstart, childcare providers and other community organizations. See Strengths and Needs Assessment.

Early Periodic Screening, Diagnosis and Treatment (EPSDT) coordinates closely with under an interagency agreement with the Department of Children and Families and the state Medicaid agency. Services for children (families making up to 300% FPL): include: education on preventive health care and age-appropriate health screening; assistance with scheduling medical, dental, and other health-related appointments; assistance in locating medical and dental providers; information/referral on health and community services, and targeted follow up. Vulnerable children are prioritized, such as those in foster care and children of migrant workers. A key EPSDT initiative that focuses on vulnerable children is the Fostering Healthy Families project. This project involves co-locating a public health nurse (either full or part-time, depending on local needs and capacity) in the child welfare office at the local level. The nurse works with child welfare staff to complete a Health Intake Questionnaire on each child or adolescent who enters state custody. This document informs a health plan for the child and is the basis for assuring that the child is seen for health supervision visits either by their ongoing primary care provider or by a new medical home. Program staff at VDH and the Family Services Division of the Department of Children and Families have enlisted the expertise of VCHIP (University of Vermont's Child Health Improvement Project) to implement the use of this standardize Health Intake Questionnaire in four pilot districts in Vermont. During the upcoming year (2005-2006) use of this questionnaire will be expanded to include as many other districts as capacity allows. The overall goal is to implement statewide so that every child entering custody will have a child welfare case file with important health information as well as a medical and dental home. Children in need of behavioral health care will also receive needed assessment and services. VDH nurses may be actively involved in finding medical or dental homes for this population and may also work with the medical home to update immunization records and collect other information necessary for ongoing

quality primary health care.

The Vermont Agency of Human Services has been undergoing major reorganization that has resulted in many of the previous departments being assigned to other, newly formed or newly consolidated departments. This effort is an attempt to make services more efficient, client-centered and accessible. Previous EPSDT efforts will continue with reorganized governmental units such as the now autonomous Office of Vermont Health Access (Medicaid). The Kids in Safety Seats (KISS) Program (in partnership with Governor's Highway Safety Program) continues to provide education to the parents of young children Also, EPSDT developed/distributed health screening recommendations and literature for Medicaid families to be aware of appropriate preventive health care. Vermont (working with AAP and AAFP) continually updates the standards for preventive care titled "Health Screening Recommendations for Children and Adolescents" and the associated Provider Toolkit of best practices. The EPSDT School Health Access Program continues to improve health access for school aged children via a variety of collaborative/community based activities -- funded by contracts from VDH to the school districts.

CISS: Health Systems development in Child Care Grant funds a public health nurse specialist to focus on the health and safety needs of children in child care settings. "Healthy Child Care Vermont" (HCCVT) builds state and local capacity to provide expert public health nursing consultation and training to child care providers. Services include workshops, education, resources, phone or on-site consultation and assistance in health and safety areas such as injury prevention, ill/sick child care, healthy eating and health environments, mental health, access and referral to health services and insurance, and emergency readiness and first aid. IN 2003, the HCCVT initiative began a transition to a new HRSA/CISS grant for infrastructure development of an early childhood comprehensive system (ECCS), which includes early care, health and education focused integration. The ECCS grant is funded by the MCHB/HRSA through Title V, to ensure there is a health presence and leadership around five key areas: access to insurance and a medical home; mental health and social-emotional development; early care and education; parent education; and parent support. Simultaneously, Vermont received a Technical Assistance grant from North Carolina's Smart Start Initiative, to develop a strategic plan for creating a unified early childhood comprehensive system which would be unique to Vermont. This work was directed by a Governor's Cabinet Sub-Committee on Early Access to Care and Education, as well as four workgroups with diverse statewide representation: local/state governance, public engagement, finance and evaluation. These workgroups reported back to the Sub-committee and assisted in informing the final strategic plan for this unified system, including a 'new' name - Building Bright Futures: Vermont's Alliance for Children. IN 2004-2005, the BBF Health Subcommittee conducted an extensive planning process -- the action plan is now being written and readied for implementation.

Nutrition Services Program (Non WIC and Non CSHN) The nutritionist position in the Department of Health Improvement continues to be vacant, although many activities continue, such as integrating nutrition into the Department of Education's Comprehensive School Health Guidelines and providing training curriculum for teachers, and activities related to reducing obesity as funded by CDC.

Dental Health Program provides dental consultation to the Medicaid/Dr. Dynasaur program by determining prior authorizations on several dental procedures, including orthodontics. A coalition coordinates Baby Bottle Tooth Decay (BBTD) prevention efforts among family practitioners, pediatricians, primary care providers, dentists, dental hygienists, and VDH. A fee under Medicaid has been established to reimburse dentists for oral hygiene instruction to parents of children under age 5. Community water fluoridation: provides promotion, TA, and surveillance. 2004: Fluoridated areas - 45 towns, 64 public water systems, and 245,233 population. Tooth Tutor, begun in 199, reaches out to low income children via Head Start and schools and supports their enrollment in a dental home. An extensive state oral health plan was created in 2004-2005 and action planning will take place in Fall, 2005 at the first State Oral Health Summit.

Emergency Medical Services - Children (EMS-C) The VDH Office of Emergency Medical Services grant has three objectives: 1) Represent pediatric emergency care issues in all aspects of the

emergency medical service system; 2) Assist with the delivery of the Family Practice Resuscitation Project to fifty family practice offices and 3) Develop a prehospital data collection plan for the Vermont Emergency Medical Service System.

Vermont Department of Health Injury Prevention Program was established in 2000 with the hiring of a coordinator via CDC funding. The Vermont Injury Prevention Advisory Committee (VIPAC) was developed and the Injury Prevention Plan was released in 2002. Priority areas include motor vehicle crashes, violence, falls and hip fractures in the elderly, residential fires, and work-related injury. An injury surveillance plan is also being created. The Program coordinates closely with MCH Planning, Community Public Health, the Child Fatality Review Committee, and Women' Health.

System of Care for Children with Special Health Care Needs:

PYRAMID LEVEL: DIRECT SERVICES:
Please see Strengths and Needs Assessment section on direct and enabling services for CSHCN; the SNA describes CSHN efforts for primary care services and the communication between primary and tertiary care.

CSHN continues to manage and subsidize a statewide network of multidisciplinary services for Vermont children with many chronic conditions. Clinics/Programs which are directly staffed and managed by CSHN include: Orthopedics (including also Hand and Myelomeningocele); Child Development Clinic, Metabolic, Craniofacial, and Feeding Clinics, and the Seating, Nutrition, and Hearing (Hearing Outreach Program and Hearing Aid Purchase) Programs. Clinics/Programs which are supported through grants and contracts, and which CSHN staff (nursing and/or social work) attend are: Cystic Fibrosis, Juvenile Rheumatoid Arthritis, and Neurology/Epilepsy. Clinics/Programs which we support through grant and contracts and with which we collaborate but do not attend staff directly include Dartmouth Child Development Program (CSHN and Dartmouth co-fund the clinic coordinator), Hemophilia, FAHC NICU medical follow-up (providing the developmental screening component) and the Community clinic of Vermont's LEND program (Interdisciplinary Leadership Education for Health Professionals--ILEHP). In the last year CSHN has become a direct provider of "Therapy Clinic" services under Medicaid, through which community based PT, OT and SLP are enrolled as credentialed providers, contractor-employees of CSHN, which, in turn, is able to bill Medicaid. The "Clinic" is not a site, per se, but delivers therapy services directly to children in their homes and communities.
CSHN continues its intensive review of the Child Development Clinic, redefining its proper niche as a provider. Between October 2004 and October 2005, three key staff members will have been retired, and another has announced his intention to retire in 2007. Recruitments are active.

PYRAMID LEVEL: ENABLING SERVICES

CSHN Financial Assistance Program: CSHN continues to provide after-insurance funding of medical services when these services have been pre-authorized by CSHN clinical staff and when they fall within the range of services permitted by CSHN guidelines. Changes (largely reductions) in Medicaid accessibility (increased premiums; tighter interpretations of medical necessity) have resulted inavoidably in some costs shifts to CSHN, but more importantly, loss of coverage of other services for CSHCN, such as primary care. CSHN staff work diligently to help families apply for and maintain their children's Medicaid coverage.

Special Services Program: CSHN continues to provide medical care coordination, through regional social work and/or nursing, and financial access to specialized services, for VT children who have a condition that CSHN covers but for which no established clinic exists. CSHN pediatric nurses and medical social workers are based in regional offices and are involved in care coordination. Families are referred to CSHN from hospitals, Medicaid high-tech program, and others; CSHN MSW's are also members of the regional Part C Core teams (direct service teams); this role has continued, even though the Part C program has been transferred to the new Department for Children and Families in

the AHS reorganization.

Please also see extensive discussion in the SNA concerning CSHN care coordination.

Respite Care Program: Families receive annual grants or reimbursements to defray the cost of hiring respite care providers. Allocations are based on the skill level of the care needed; eligibility is based on enrollment in CSHN, income and ineligibility for respite care from other programs. In 2004, a modest increase in the Respite Line item allowed expansion of supports. Parent to Parent of Vermont receives funding from CSHN to support its statewide network of programs, which include supporting parents, outreach to community providers, pre-service and in-service training to medical and early intervention staff and students, continuing education, and participation in program and policy design for CSHN. Part of the funding specifically supports a parent as Children's SSI Coordinator, providing outreach information and referral.
In-Home Support Program: Medicaid funds Personal Care Services (PCS) for in-home support for children with severe disabilities. CSHN serves as one of several access points providing referral to PCS.
Nutrition Services: CSHN/Part C-IDEA and a state-level pediatric nutritionist who is developing and expanding the capacity of community-based nutritionists to provide local consultation to CSHCN. The state CSHN nutritionist reviews each client evaluation, assists in the development of the plan of care, and provides technical assistance in the treatment. CSHN also manages a nutritional formula program for children needing special formulas or "nutriceutical" treatment of their chronic condition. CSHN developed agreements with the major insurers and Medicaid to function as a clearinghouse for medical foods for children.
Family Support Services: CSHN provides support to Parent to Parent of Vermont for its support of families, and for its annual Partners in Care family/provider collaboration conference. The respite care program described above is also one of CSHN's Family Support Services.
Family, Infant and, Toddler Project (FITP) is the statewide early intervention system of care for infants and toddlers with developmental disabilities, funded by Vermont's federal Part C-IDEA grant. FITP was transferred to the new AHS Department of Children and Families for continued administration and for delivery of services regionally. Each of the 12 AHS districts has established its own regional planning team, designated host agency and developed programs that comply with Part C rules. CSHN regional social workers are members of FITP regional interdisciplinary service teams, smoothing the transition at the child's 3rd birthday and offering some continuity in a child's team composition.

PYRAMID LEVEL: POPULATION-BASED SERVICES

See also the Strengths and Needs Assessment.

Newborn Screening Follow-up: See discussion in NPM 1. Vermont has strong newborn screening programs, assuring that over 90 percent of all newborns are screened in a timely way and receive timely followup. Vermont recently expanded the number of congenital conditions for which babies are screened, from 7 to 21 conditions. Since July 2003, all VT birth hospitals have screened all newborns for congenital hearing loss. CSHN is responsible for the assurance and follow-up, overseen by a full time pediatric audiologist (through a grant to UVM; not a state position as yet), and largely implemented through the direct service of the Hearing Outreach Program, also by pediatric audiologists. As with many states, we are charged with sustaining these population-based efforts through fees, rather than grants. We utilize third party billing for HOP, and are examining asking the legislature to increase the newborn screening fee to cover the remainder. The VT legislature has passed the Birth Information Network statute, and the CDC has funded its initial development and implementation, with the goal of earliest possible identification of certain congenital conditions and the assurance that identified babies have access to needed early intervention and health services. CSHN also participates in population-based screening (by referral) through HOP for older children up to age three, or those of any age who are difficult to screen by other methods.

PYRAMID LEVEL: INFRASTRUCTURE-SYSTEM BUILDING ACTIVITIES

Please see also the Strengths and Needs Assessment.
"Children receive regular ongoing care within the medical home" See NPM 3, P Need 1.
"Families have adequate insurance to pay for needed services" See NPM 4.

With the expansion of Dr. Dynasaur (Medicaid and CHIP) to 300%FPL, Vermont continues to improve the percentage of children who have a source of adequate health care coverage. As a payer of last resort for many necessary medical services, CSHN has developed and strengthened its internal financial processes for helping families to apply for Medicaid, understand their own private health insurances, and pursue benefits to which they are entitled. In the gap, CSHN has continued to be a payer. Medicaid has delegated to the CSHN director the responsibility for determination of the medical necessity and authorization of continuation of services for OT, PT, and speech services for children after they have received them for a year. Through its Seating Clinic, CSHN also reviews and facilitates the ordering of wheelchairs and other seating and positioning equipment, as well as the coordination of insurance and Medicaid coverage for the equipment. At the same time, the collaboration with Medicaid in the prior authorization of individual services also is the basis for systems-level solutions to coverage issues that arise with individual children. In 2000, the CSHN director began to meet regularly with the Medicaid Policy Chief, to discuss and resolve policy issues.

Community Capacity and Statewide Building: See Strengths and Needs Assessment

C. ORGANIZATIONAL STRUCTURE

The Agency of Human Services is the largest of the agencies of state government, and is headed by the Secretary of Human Services, who reports to Vermont's governor. The Vermont Department of Health (VDH), within the Agency of Human Services (AHS), administers the Maternal and Child Health (MCH) Block Grant, also known as Title V. Most Title V activities occur through two of the six divisions of the Vermont Department of Health: the Division of Community Public Health and the Division of Health Improvement. The Division of Health Improvement includes the programs of Children with Special Health Needs which are overseen by a medical director. The MCH Director, who is also the Director of the Division of Health Improvement, has the responsibility for the implementation of the entire Title V grant. As part of the oversight of the grant, the MCH Director meets regularly with the appropriate partners within VDH, with outside contractors receiving funds from Title V, and with state and community partners involved in MCH related activities. The Division of Community Public Health has oversight of the WIC Program, Healthy Babies, Kids, and Families, EPSDT, and the twelve VDH district offices. (See Strengths and Needs Assessment for organizational charts.)

D. OTHER MCH CAPACITY

Commissioner of Health
Dr. Paul E. Jarris, MD, MBA, was appointed Commissioner of the Vermont Department of Health in 2003. Dr. Jarris graduated from the University of Vermont and received his MD degree from the University of Pennsylvania School of Medicine in 1984. He interned at Duke-Watts Family Medicine Residency Program in Durham, NC and completed his residency at the Swedish Family Practice Residency Program in Seattle, Washington in 1987. Following residency training, he completed a fellowship in Faculty Development and received a Masters in Business Administration from the University of Washington in 1989. Dr. Jarris served as Medical Director for Vermont's largest nonprofit HMO; Community Health Plan, from 1992-1996. In this capacity he had responsibility for quality improvement, resource management, practice relations, and medical affairs. He was President and

CEO of Vermont Permanente Medical Group from 1998-2000 as well as CEO of Primary Care Health Partners, Vermont's largest statewide primary care medical group, from 1999-2000. Throughout his career, Dr. Jarris has maintained an active clinical family practice, including work in federally qualified health centers and a shelter for homeless adolescent youth. He is certified by the American Board of Family Medicine and the American Board of Medical Management.

Division Director of Health Improvement and Director of Maternal Child Health
Donald Swartz received his MD degree from West Virginia University in 1963. He interned at West Virginia University Hospital and then completed a residency in Pediatrics at Children's Hospital in Cincinnati, Ohio in 1966 and served as Chief Resident there until 1967. He was in private practice of pediatrics from 1968 until 1986 and then in private practice of Pediatric Pulmonology until 1999 when he was appointed to his current position. He directed the Vermont Cystic Fibrosis Program from 1968 to July, 2000. He is Board Certified in Pediatrics and in Pediatric Pulmonology, and holds an academic appointment at the University of Vermont College of Medicine where he is a Clinical Professor of Pediatrics.

Division Director of Community Public Health
Patricia Berry earned a BSN from Boston College in 1969 and a Master of Public Health (MPH) degree from Johns Hopkins University, School of Hygiene and Public Health in 1982. Ms. Berry's has eight years of public health nursing experience, served as Public Health District Director in Vermont (1978-1981) and as Public Health Planning and Policy Chief for the Vermont Department of Health (1982-1984). She has served in her current position as Director of the Division of Community Public Health at VDH since 1984, providing leadership and oversight of the state's local public health system and the WIC, EPSDT, Healthy Babies and other MCH programs.

Director of Children with Special Health Needs Programs
Dr. Carol Hassler graduated from Radcliffe College in 1972 and earned a MD from the University of Pennsylvania in 1976. Her residency in Pediatrics took place (in 1976-1978) at the University of Virginia, and Dr. Hassler held a fellowship in Child Psychiatry at the University of Virginia (1978-1980), where she also served as Chief Resident from 1979 to 1980. She has served as the Director of the Division of Children with Special Health Needs at the Vermont Department of Health from 1990-1995, and Director of Handicapped Children's Services at VDH from 1985-1990. She is Board-certified in pediatrics and is a Fellow of the AAP. Dr. Hassler also serves as Clinical Associate Professor of Pediatrics at the University of Vermont College of Medicine and as an Attending Physician at the Fletcher Allen Health Care Hospital.

Director of Dental Health
Dr. Steven Arthur graduated from West Virginia University School of Dentistry in 1968, entered the US Navy as a Navy dentist and was stationed in Iceland from 1968-70, then Memphis, TN, from 1970-71. He conducted a private practice of dentistry in Castleton and Fair Haven, Vermont from 1971-79. Dr. Arthur reentered the Navy in November 1979, being stationed in Cherry Point, NC. From 1981-84, he was on the USS Midway aircraft carrier in Yokuska, Japan. In 1984, I entered the Masters of Public Health program in Bethesda, MD, followed by a one year Dental Public Health residency at the National Institutes of Dental Research, National Institutes of Health, Bethesda, MD. In 1988, he became Board certified in Dental Public Health. From 1989-93, he was the Chairman of the Research Department at the Naval Dental Postgraduate School, Bethesda, MD. From 1993-96, he was Executive Officer of the Naval Dental Center, Pensacola, FL. From 1996-2000, Dr. Arthur was stationed in the Washington, DC area and retired from the Navy on January 1, 2000. Dr. Arthur came out of retirement to take the position of Director of Dental Health in May, 2005.

Nutrition Chief
This position is currently under recruitment.

MCH Planning Specialist
Sally Kerschner holds a Masters of Science in Nursing from the University of Vermont and is a Registered Nurse. She has twenty-five years of experience in maternal and child health and

community health nursing. She has worked at the Vermont Department of Health since 1983.

CSHN/Parent to Parent
Through CSHN funding of Parent to Parent of Vermont, CSHN hires parents as Children's SSI Coordinators, providing outreach to Vermont families whose children are eligible for SSI. In addition, seven of the CSHN clinical staff are parents of children with special health needs.

E. STATE AGENCY COORDINATION

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The Vermont Agency of Human Services has been recently reorganized and now consists of consists of the Department of Health, the Department for Children and Families, the Department of Disabilities, Aging and Independent Living, the Department of Corrections, and the Office of Vermont Health Access. AHS has twelve field offices that coordinate closely with the Department of Health's twelve District Offices. The VDH District Offices serve as local health departments and cover the entire state. The local district offices of the VDH work closely on case management and service coordination with the local state (such as those listed above) and community offices that provide social, health and welfare services. The local district offices also are developing close ties with the community health centers that provide services in their regions and the AHEC districts. At the state level, the community health centers are part of the Primary Care and Rural Health programs. Within the Department of Health, close working relationships exist among the divisions of Health Improvement (which includes the CSHN Programs), Community Public Health, Health Surveillance (epidemiology and statistics), Health Protection, and the Alcohol and Drug Abuse Programs and Mental Health Services. All VDH Division Directors meet at least monthly to coordinate VDH activities. In addition, a close relationship exists between operations and program planning and the data and research office of the VDH. Just a few examples of this collaboration are the CSHN Measuring and Monitoring Project, the evaluation of the Healthy Babies Program, SSDI-funded act ivies, and Injury Prevention.

Overall, there are a wide variety of public health planning, coordination and program activities that have evolved over the past several years which include a wide ranges of health and health-related partners both within state government and also the community or private sectors. These collaborations deal with such public health issues such as primary health care delivery, women's health, oral health, obesity, emergency preparedness, health in the schools, injury prevention, QI in health care services, etc. Several examples are detailed below. It has become the culture at VDH and within MCH programs that, to be successful with achieving the goals of any major new public health initiative or project, key community and state partners must be involved. Public health issues are complex and require complex solutions -- which can be implemented via a multidisciplinary approach. With many of these issues, the VDH plays the key role of speaking for public health and modeling the unique role that MCH and public health can offer to the population health solution.

The Vermont State Team for Children, Families, and Individuals:
Among the Departments within the Agency of Human Services, a unique collaborative relationship exists through the Vermont State Team for Children, Families, and Individuals. The State Team is a multidisciplinary, statewide collaborative effort comprised of representatives from the various state agencies and departments including Developmental and Mental Health Services, Social and Rehabilitative Services, Welfare, Health, Education, the University of Vermont, parent groups and community coordinating councils. Its mission is to "support the

creation and maintenance of effective services for children and families through partnerships with families and communities." One feature of the State Team that is particularly advantageous for collaborative working relationships throughout the state is the presence and participation of Community Partnership groups from all 12 AHS districts, which closely mirror the health districts. Each of the 12 Community Partnership groups have a liaison member at the monthly State Team meetings. The State Team provides support to the Community Partnerships which coordinate health and human service efforts at the district/community level. In each district, the VDH district director is a key member of the Community Partnership team. The MCH Director and a number of other members of the MCH staff also serve on the State Team. One central focus of the State Team has been to formulate common desired outcomes shared by families, advocates, and service agencies, and to determine specific indicators that will allow progress toward achieving these outcomes to be tracked by community and state partnerships. State Team meetings focus on selected outcomes, reviewing interventions and programs that have been proven effective (compiled into a series of documents called "What Works") and activities that are taking place in Vermont to influence the selected outcomes.. AHS also publishes Community Profiles for each of the School Supervisory Unions in the State. These profiles reflect the outcomes and indicators chosen by the State Team, allow for tracking of progress on outcomes, and also provide a basis for community planning. VDH district directors facilitate use of the data from these profiles and other resources in the community planning process. The State Team supports the community assessment process by providing data on outcomes, provides training and technical assistance, and whenever possible, provides financial support to help achieve agreed upon outcomes for children and families. Recently, the Outcomes Planning by the state Team has been incorporated into the ECCS-funded planning and also the assessment and planning process for the Title V Strengths and needs Assessment.

The Vermont Primary Care Cooperative Agreement: Purpose is to coordinate state primary care activities that promote the development of innovative and progressive primary care health care services for the underserved. The Vermont PCCA provides opportunities for community-based providers of primary and specialty care to work together on state and regional issues and promotes the support and involvement of state agencies in primary care. The PCCA includes representation from the following organizations, agencies, and institutions: Vermont's Agency of Human Services (Department of Health and the Office of Minority Health, the Department of Developmental and Mental Health Services, Department of Prevention, Transition, and Health Care Access (Medicaid); the University of Vermont (College of Medicine, School of Nursing, Department of Dental Hygiene); Imani Health Care (serving the African American, Latino, Asian, and Native American populations); Bi-State Primary Care Association; Dental Society; Health Care Authority; Coalition of Clinics for the Uninsured; Vermont Association of Hospitals and Health Systems; Medical Society; Nurses Association; Northern Counties Health Care; the Vermont Long term Care Coalition; and the Area Health Education Centers. IN 2004, a main focus was assessment and planning for oral health service needs in Vermont.
Another major activity has been participation in the Healthcare Workforce Development Partnership, which has initiated a project to review the current healthcare workforce status in Vermont, assess supply and demand problems for selected priority professionals and recommend strategies to address identified issues. The Partnership membership consists of key stakeholders in the training and employment of healthcare professionals in Vermont. A draft report has been circulated for comment and revision.

Coordination of Health Components of Community and State-Based Systems:
The Division of Community Public Health has strong liaisons with Head Start, Early Head Start, and other early childhood programs. Staff from the Immunization Program in the Division of Health Surveillance and staff from the Division of

Community Public Health work collaboratively with the AHS Division of Child Care to increase the percent of children in child care who are fully immunized. Vermont Department of Health staff participate in the statewide Early Childhood Workgroup, which was established to coordinate efforts between a variety of state agencies and private, not-for-profit community organizations.

To address quality improvement for children using Medicaid, VDH has contracted with the University of Vermont College of Medicine's Vermont Child Health Improvement Program (VCHIP) to plan and implement numerous quality improvement projects with a wide range of providers and institutions. Projects ranging from improvement of OB care in Vermont birth hospitals to improvement in adolescent health supervision have involved a broad range of state agencies, providers of pediatric care, private health insurers, and consumers and has resulted in national recognition. Fro example, VDH and VCHIP are working closely with the child welfare agency to implement the use of a uniform health intake questionnaire for use when a child enters state custody. This document identifies immediate and chronic health needs, existing providers involved in the child's life, and needs for linkages to new providers. This tool is intended to inform the development of an action plan to address the child's physical, mental, and dental health. It is an example of collaborative work that brings together expertise and skills that may otherwise not be available in a single state agency or private institution.

Historically, work originally funded by two CISS grants from the Maternal and Child Health Bureau has been able to increase the capacity of the VDH to focus on child and adolescent health systems development. The first grant was used to begin the process of updating the Vermont EPSDT periodicity schedule, which is being used as a vehicle to promote new approaches to child and adolescent health supervision, in particular, emphasizing health promotion and the prevention of psychosocial morbidity. Specific goals include streamlining or eliminating duplication in the delivery of child and adolescent health screening services and assisting VDH district offices in developing strategies to create, sustain or strengthen local systems of care and capacity to serve children, adolescents and families referred as a result of screening. The second CISS grant, Vermont Health Systems Development in Child Care increased the capacity of VDH to make health and child care a focal point in systems development efforts at the state level and created an interdisciplinary, community-based model for providing technical assistance to child care providers concerning health and safety issues. Staff from both projects continue to work (after the end of the formal grants) with the Early Childhood Work Group, Head Start, other state-level departments and agencies (e.g., the Department of Children and Families, the Child Development Division, the Department of Education, and Mental Health Services newly located within the Department of Mental Health), and with private sector partners (e.g., the Vermont Chapters of the AAP and AAFP).

The Vermont Department of Health works closely with the tertiary care facilities that provide services to Vermonters (Fletcher Allen Health Care in VT, Dartmouth Hitchcock Medical Center in NH, and the Albany Medical Center in NY). Services are provided through the Newborn Intensive Care Units (NICU), the maternity service departments, health service providers through the Healthy Babies system of care and the CSHN programs. In addition, the Regional Perinatal Program (partially funded by Title V) provides training and data analysis to participating birth hospitals in Vermont and New York State.

In other activities, the VDH has student nursing placements from the University of Vermont (Baccalaureate and Masters level), Norwich University, and Castleton State College nursing programs. Student placements are also provided for the Master of Social Work program and the Nutrition program at UVM. The Director of the Division of Community Public Health serves on the state team for the children's mental health grant, the Children's UPstream Services (CUPS) project. The VDH is represented on Vermont's Interpreter Task Force. This is an interagency collaboration which develops and conducts non-English language

interpreter and translator training activities. The task force monitors the need for interpreter services by Vermonters who don't speak English as their first language. VDH representation is via the Office of Minority Health and the Refugee Health Coordinator.

The VDH is represented on the state advisory team on welfare reform and continues to work with the Office of Vermont Health Access and the Department of Children and Families in a variety of initiatives to coordinate programs and activities. Improvements continue to be made to the WIC/Medicaid combined application and eligibility determination process, for example, and VDH and the Department for Children and Families collaborate to improve services and outcomes for parenting teens and their children.

The Vermont Department of Health has collaborated extensively with the Medicaid program in the implementation of the 1115 waiver, in meeting with managed care providers, and in planning for the CHIP benefits expansion. The state received a Robert Wood Johnson grant to improve outreach and enrollment of children in Medicaid and CHIP (Covering Kids). In April, 2004, the Governor submitted to CMS a proposal called the Global Commitment which would pilot for five years a new approach to Vermont's Medicaid program. Under the Global Commitment, all Medicaid funding would be capped with an agreed percentage increase per year over the five year period. In exchange, Vermont would receive greater flexibility in the administration and benefit design for all Medicaid programs. If approved, the administration is planning for a July, 2005 start-up date. In par, the administration wishes to develop mental health programs with an emphasis on early prevention and screening within a pediatric setting.

VDH continues to coordinate efforts with the Department for Children and Families n the Fostering Healthy Families initiative, a program that addresses the health needs of children in state custody. Work between the DCF District Directors and the VDH District Directors is being done to stimulate closer relationships at the local level toward achieving the goal of improving the health of children in state custody.

Historically, the VDH works with the Department of Education through the "Success by Six" and "Success beyond Six" programs. Another important collaborative relationship exists through the EPSDT School Access program. Each VDH regional office has a public health nurse/school liaison assigned to the task of improving access to health care for school aged children and strengthening the connection between VDH and the schools within their health district.

In the past two years, the Coordinated School Health grant from CDC has allowed a more comprehensive approach to coordination between VDH and the Vermont Department of Education for all issues relating to a broad definition of school health. Goals of the program include increasing communication and collaboration between DOE and VDH on all levels, especially at the state planning level and within individual schools. A statewide coordination committee has been established between the DOE and VDH. Also, an internal VDH committee enables communication to streamline VDH actions in health programs in the school. In addition, each participating school or school district is encouraged to create a School Health Action Committee, that plans individual school responses to the nine components of the School Health Model (such as enhancing clinical services, supporting healthy nutrition, promoting staff wellness, etc.)

The VDH works with the Department of Corrections through local community partnerships, Domestic Violence Task Forces, and child protection teams. For families who have a family member assigned to probation and parole, services are provided through local case management and Community Partnership meetings. Also, in FFY 2004, new planning efforts are being encouraged between the VDH and Department of Corrections. VDH is taking a more active role in the planning and delivery of health care services to both men and women

in correctional facilities - VDH being asked to provide QI oversight to existing clinical health services. IN 2004, a needs assessment of the health needs of women in the correctional system, was written, with special emphasis on reproductive health needs and referral to community based clinical providers after discharge from inmate status. In districts where correctional facilities with women inmates are located, VDH district office staff work closely with Correctional personnel to assure that eligible women are enrolled in WIC and receive seamless services for themselves and their children upon return to the community.

The VDH works closely with the Vermont Area Health Education Center (AHEC). Examples of collaborative activities are as follows: Office of Minority Health provides trainings to AHEC staff on cultural competency, VDH coordinates with AHEC in a variety of community activities, The Office of Tobacco Control coordinates with AHEC on provider training re: brief intervention for smoking cessation and collaboration on health care professional workforce issues.

The Office of Minority Health has been engaged in a major statewide strategic planning effort that involves collaboration within the VDH and also engages key state and local stakeholder who are involved in minority health, such as health care providers, social service providers, members of minorities, and representatives of community based organizations.) Goals are related to reducing disparities which are specific to Vermont and to increase the cultural competency of service providers, using the planning framework set up by the Vermont Blueprint for Health. (See also IIIB. Agency Capacity)

Child Fatality Review Committee: is a multidisciplinary team that reviews the deaths of all resident children, ages 0-18, with particular attention to child protection/neglect issues and systems issues that may need to be addressed in order to prevent child and adolescent fatalities. Over the past two years, the Committee has begin to focus on child deaths from all unnatural causes, not just abuse and homicide. The Title V Planner, the Injury Control Coordinator, and the Office of Research and Statistics have been planning for a system of data collection based on the uniform data set developed by the National Center for Child Death Review. Also, in response to an informal review of Vermont "SIDS" deaths, a parent education pamphlet on safe sleep environment was produced.

State Agency Coordination for CSHN: CSHN participates in a variety of interdepartmental planning and policy-making settings. Please see IIIB. Agency Capacity--CSHCN--Pyramid Level Infrastructure, above. CSHN has a particularly close relationship with Medicaid, promoting and assisting eligibility for children, collaboration in the area of prior-authorizations, and reimbursement of CSHN program activities for Medicaid children, through fee-for-service and Medicaid Medical Case Management/EPSDT.

F. HEALTH SYSTEMS CAPACITY INDICATORS

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HSCI #01: The rate of children hospitalized for asthma.

The Asthma Program, begun in 2001 (via CDC planning grant) has achieved its initial goals of developing an asthma surveillance system and creating a state asthma plan. The largest number of children admitted for asthma are in the under 5 year age group. In this under age five group, twice as many are boys than girls. The program is now entering a 3 year implementation phase. Activities during 2002-03 designed to improve services to children include: 1) Creation of 3 brochures targeting children 0-5, 6-13, and teens, describing how to live a healthy life with asthma. They were distributed to all Vermont physicians, hospital

Emergency Rooms, VDH clinics and school nurses. 2) Creation/distribution of Vermont Asthma Action Plan to all pediatricians and school nurses. 3) Development/distribution of radio spots. 4) Placing resources for parents on VDH website. Pending availability of funds, other activities such as education and support of childcare providers and a QI project for physicians and school nurses will be implemented. Increased surveillance capacity has enabled better data to be obtained from hospital discharge data and emergency department data. Improvements include: obtaining counts of individuals vs. events of hospitalization, analysis of rehospitalizations, and inclusion of a question on the BRFSS about presence of children in the home with asthma. Progress has been made in obtaining data from Medicaid via a report card from the PC Plus population form the Vermont Program for Quality in Health Care. The Behavioral Risk Factor Surveillance System continues to be a valuable tool for measuring asthma prevalence as well as measures of morbidity and treatment-seeking behavior in adults. For children, Vermont has included questions by proxy on the BRFSS (years 2001, 2002, 2003, 2004 and 2005) to assess childhood asthma prevalence. Unfortunately, due to the formatting of the questionnaire, there have been difficulties in weighing the data for years 2001-2004. IN 2005, a "Random Child Selection module was added to the questionnaire which will help in obtaining a reliable measure of childhood asthma prevalence through the BRFSS. The Asthma Program was also able to include a question on lifetime asthma diagnosis, in addition to several questions on asthma morbidity and asthma treatment-seeking behaviors, the Youth Tobacco Survey, asked of middle and high school students in 2004.

HSCI #02: The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen.

Vermont's generous Medicaid health insurance enrollment criteria and benefits does not automatically insure that children will receive ongoing health care. Included in Title V measures are those concerning children who received a Medicaid-funded service, infants who received preventative visits, and children (aged 6-9) who received a dental service. Under the funding provided by SSDI, Vermont has expanded capacity to perform analyses of Medicaid claims files. Over the next year, Vermont will be able to perform a more sophisticated examination of the patterns of health care utilization of services by children and families enrolled in Medicaid as part of the SSDI grant activities. For example, over the past five years, data for State Performance Measure #9 show that the percent of Medicaid eligible children who use dental services (within a one year period) has yet to reach the 50% level. In partial response, VDH is creating a public media campaign encouraging lower income parents to take their children to the dentist for preventative care. (See also 2005 Strengths and Needs Assessment)

VDH continues updating of the Provider's Toolkit for the dissemination of best-practice guidelines and screening tools to providers of pediatric care. VDH staff work with AAP and AAFP monthly to identify system, policy, clinical or reimbursement issues that might pose a barrier to Medicaid-eligible children receiving routine, high-quality preventive care. Data is guiding the development of this toolkit information -- for example, analysis of injuries to children by age and type of injury give information as to how Vermont children are being injured and how providers and parents can be guided by age-specific information to reduce the risk to their children.

Continuing development of provider guidelines that clarify CPT coding procedures for providers to bill for the provision of routine EPSDT screenings. Previously, many services which are actually unbundled from the routine EPSDT visit were thought to be bundled. Clarifying of these procedures was an attempt to facilitate provision of these services.

HSCI #03: The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one initial periodic screen.

Vermont's SCHIP enrollees receive the same benefits as those offered by Medicaid, and the SCHIP data is contained within the Medicaid enrollment and claims data bases.

HSCI #04: The percent of women (aged 14-44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80% on the Kotelchuck Index.

In 2001, Vermont revised the method used to calculate weeks gestation to better match the methodology used by NCHS. Since weeks gestation is one of the variables used to compute the Kotelchuck Index of Adequacy of Prenatal Care, this change affected the Kotelchuck Index values. Values for the years 1998-2000 have been recalculated following these new definitions. The value for 2002 is 87.1 percent, reflecting a steady increase since 1998. VDH efforts such as prenatal outreach via Healthy Babies, Kids and Families and EPSDT efforts to increase access to medical care for pregnant women are geared to continually improving this percentage. Efforts are ongoing to work with birth hospitals to improve accuracy in the count of prenatal visits in the last trimester. Vermont received a Pregnancy Risk Assessment Monitoring System (PRAMS) grant in 1999 and is now reviewing the first set of analyses from the state-specific weighted data files. Information from the PRAMS survey will be used to identify barriers to prenatal care in the state. Efforts can then be made to reduce these barriers. Additional work is being completed on the use of provider generated delivery data (OBNET) which will reflect more accurate count of prenatal visitation. Expansion of the OBNET program is planned for more VT birth hospitals to be able to directly download birth data and increase the accuracy of the information.

HSCI #05: Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State.

The SSDI funding has enabled increased capacity for VDH to obtain this data from several data systems, especially Medicaid and birth certificates. The data show a statistically significant higher rate for families with Medicaid versus those families using other insurance in the following: percent of pregnant women receiving prenatal care in the first trimester, and percent of pregnant women with adequate prenatal care. The indicator of infant death rate showed no statistical difference, due to small numbers. These results will be used for planning and program priorities within VDH systems and for the Infant Mortality Committee. In addition, collaborating with VCHIP on Improving Prenatal Care pregnancy outcomes and injury prevention data elements will result in agreed-upon statewide standards and also data to demonstrate demographic differences.

HSCI #06: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants(0 -- 1) children, and pregnant women.

Vermont's eligibility for Medicaid and SCHIP are the same at 300% of FPL for infants and children up to age 18. Pregnant women under 200% FPL are also eligible.

HSCI #07: The percent of EPSDT eligible children aged 6 -- 9 years who have received any dental services during the year.

The Dental Unit continues to promote outreach and the development of a dental home. For activities, see discussion under the 2005 Strengths and Needs Assessment and NPM #9 . In the fall of 2002, state monies enabled a survey of third grade children to determine the presence of sealants, resulting in a rate of 66% of those third grade children examined. Medicaid claims data shows that 62.4% of clients have received dental services during FFY 02, similar to the 61.2% of children reported for FFY 01. Continued collaboration with EDS and the developing data analysis expertise of dental staff and VDH statisticians enable an enhanced ability to obtain

complete and accurate information from Medicaid claims and enrollment data. Also, using funding from an Oral Health Robert Wood Johnson Grant, focus groups of low income families were conducted - themes addressed were among the following: dental home, insurance coverage of dental services, transportation, ability to attend appointments, knowledge of preventive oral health. The results of this data are have been analyzed and the findings have been used to create a public media campaign on preventive oral health and also will be used to guide recommendations for the state oral health plan.

HSCI #08: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN Program.

In VT, all children who receive SSI are also Medicaid recipients. Many are also enrolled in one or more CSHN programs, for care coordination, and for clinics and financial assistance where needed. Many also receive services from sister state programs within the Division of Developmental Services. The measurement of this outcome is cumbersome and involves cross-matching Medicaid claims data with CSHN enrollment data, as electronic cross matching is not yet available. CSHN programs include access to care coordination, and some include clinic visits and help with health care costs not otherwise met by Medicaid. In continuing policy-level involvement and other current activities, the AHS reorganization will bring together partnering units (CSHN, Developmental Services, Part C) from new departments, but with common goals. Also, a chronic issue is the critical shortages in nursing and attendant care demand particular attention.

HSCI #09(A): The ability of the States to assure that the MCH Program and Title V agency have access to policy and program relevant information and data.

The Vermont Department of Health (VDH) is committed to developing and evaluating programs based on data and analysis. Infant death certificates have been matched to birth records since 1979. These records are matched as the death records are received. WIC records have been matched to birth and fetal death records annually since 1994. This linkage was developed as part of CDC's Pregnancy Nutrition Surveillance System. Although CDC funding has ended, VDH continues to match records annually, and has extended this linkage to Healthy Babies, Kids and Families data.

In the past two years, with support from the SSDI grant, Vermont began linking the metabolic screening records and Medicaid birth records to the birth certificate. We plan to continue to link these files on an annual basis.

On June 1st, 2004, Vermont implemented an interim tracking system for universal newborn hearing screening. Screening staff at the hospitals complete a form which is then sent to the Department of Health, where the information is entered into a database populated by the metabolic screening data. This system allows a closer monitoring of the hearing screenings performed and to further insure that no newborns are missed. Over a year's worth of experience with the database allows a more accurate approach for NPM 12. We are continuing to refine and analyze the data.

However, there are limitations to this system. The demographic information and some of the risk factors on the screening form duplicate information collected on the birth certificate. Some of the risk factors are contained on the mother's, rather than on the infant's medical record, and newborn screening staff do not always have ready access to the mother's medical record. The procedure of filling out a paper record at the hospital and mailing it to the Health Department where it is data entered is an inefficient one. Incorporating newborn hearing screening as part of the birth certificate will be more efficient for both hospital and Health Department staff. Vermont is planning to implement the revised birth certificate with a new web-based electronic system. We expect to integrate the newborn hearing screening information into the birth certificate system by January of 2006.

Hospital discharge data are available for all discharges from Vermont hospitals, and Vermont resident discharges from hospitals in New Hampshire, Massachusetts and New York from the early 1980s. Outpatient surgery performed in Vermont hospitals has been available since 1990. Beginning with the 2001 data year emergency department data has become available from all Vermont and New Hampshire hospitals. As part of the SSDI grant activities, detailed analysis of the hospitalizations and emergency room visits of children are being conducted.

Although Vermont has several data systems that can be used to identify and track medical conditions evident from birth, the state does not have a specific birth defects registry. In the fall and winter of 2002-2003, a legislatively appointed commission met to determine the best system for Vermont. An overall recommendation for a Birth Information System was set forth. In 2003, Vermont received a birth defects surveillance system grant from the CDC. In 2004-2005, the Project Coordinator is working through the planning stages of the grant activities

Vermont began collecting data for the Pregnancy Risk Assessment Monitoring System in January of 2001. We recently received our first PRAMS weighted data file and have begun analyzing the data. Preliminary results are reflecting the 2005 Strengths and Needs Assessment.

VDH is collaborating with FAHC on the development of the regional/statewide OBNet system. Planning for provider generated birth-related data downloaded directly into the birth certificate data system. Goal is to attain more accurate and timely birth data for such uses as clinical follow up, hospital-specific data, and for public health planning. CSHN has just received a CDC Cooperative agreement which will support improvements in the OB-NET/VDH/CSHN linkage to integrate newborn screening data with prenatal, birth certificate, and immunization data.

Ongoing data-related activities from the CDC Nutrition Grant include: 1) Presentation & discussion with VDH district directors and supervisors on how to use and interpret nutrition surveillance data in planning and program monitoring. 2) Meeting with various stakeholder to review relevant research on childhood overweight and obesity. 3) Discussion with program and surveillance staff about potential improvements to nutrition surveillance systems. 4) Investigate and pilot test record linking for longitudinal monitoring of health status indicators in the WIC program population. Linkages would make it possible to look at health status indicators for women across pregnancies, and for children from prenatal influences to age 5.

HSCI #09(B): The ability of the States to determine the percent of adolescents in grades 9 -- 12 who report using tobacco products in the past month.

The Youth Risk Behavior Survey is conducted in grades 8 -- 12 every two years. Because of the strong interest in the data available from this survey from both educational and health professionals, approximately 94% of all eligible schools participate (HSCI 9B and 9C). YRBS data show a reduction from 21.8% (in 1999) to 12.7% (in 2001) to 11.1% (in 2003) for the percent of eighth grade youth who smoke. This dramatic decline is heartening, yet the VDH and its partners continue to work with youth on prevention and cessation programs (see discussion for SPM #6.) Vermont participates in the Youth Tobacco Survey. In 2002 only middle school aged children were surveyed, however in 2004 the survey was expanded to include both middle (81 schools) and high schools (32 high schools.) In 2006 the survey will be repeated with a more sophisticated approach to sample size and obtaining weighted data. The long term goal is to develop a comprehensive school health survey that would ask about such conditions as diabetes, nutrition, physical health, asthma and youth assets

HSCI #09C: The ability of States to determine the percent of children who are obese or overweight.

A grant request for obesity prevention has been received from the CDC in July, 2004. The grant supports the creation of a statewide coalition to develop a comprehensive nutrition and physical activity plan for the prevention of obesity and other chronic diseases. The plan will include strategies for integration and collaboration between programs such as WIC, Comprehensive School Health and the Department of Education as well as strengthening data gathering capacity beyond the traditional WIC and YRBS data bases. The draft of the Obesity Burden Report, created with funding from the CDC grant, has been completed in June, 2005 and the data are being used to guide planning -- results are used to inform the Title V Strengths and Needs Assessment.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

A. BACKGROUND AND OVERVIEW
Vermont continues to work toward goals of promoting a comprehensive system of care for its MCH population which includes both clinical health care and population based services. The Vermont Department of Health has been working towards the overall goal of ensuring access to care for its MCH population. Along with this goal, comes the responsibility to build a comprehensive system of care that is of a high quality and responsive to the needs of the population. VDH has promoted the medical home concept for both medical and dental health care needs. To this end, VDH has worked to establish strong relationships with a myriad of organizations, such as professional groups, hospitals, community-based organizations, home health agencies, schools, and so forth. The VDH's Blueprint for Health (Chronic Care Model) is a specific action plan for these long-standing goals by enhancing the quality of health care and promoting client self-management. Please also refer to the 2005 Strengths and Needs Assessment for a complete discussion of the MCH population status and organizational capacity of VDH and related MCH agencies.

Evidence of success in Vermont has been revealed though many of the Title V measures and similar data. Vermont has one of the lowest teen birth rates nationally (6.7/1,000 births to women aged 16-17.) VDH continues to work at providing support and prevention services to all teens and support services to pregnant and parenting teens. Recent coordination efforts, such as the Coordinated School Health Committee, are enabling an enhanced collaboration between prevention programs. These programs cover a variety of prevention activities, such as physical fitness, good nutrition, tobacco, drug and alcohol use, mental health and sexual activity, and are broadly aimed at supporting assets in teens and promoting healthy development. Other successes include Vermont's ranking as fifth lowest in its percent of low birth weight, there is more work to be done when comparing Vermont's LBW figures to white rates nationally. VDH planning and assessment is also focused on economic disparities, such as those revealed through the data found in HSCI #5, showing a more negative rates for the measures of low birth weight and rates of prenatal care utilization for women using Medicaid insurance.

The collaborative efforts addressing birth outcomes, such as HBKF, WIC, quality improvement projects and enhanced surveillance capacity address the broad measures of perinatal health. In 2003, the infant mortality rate in Vermont was 5.0/1,000 live births. Although this rate fluctuates, it remains above the HP 2010 goal of 4.5/1,000 and is higher than the national white IMR. The leading causes of infant mortality in Vermont continue to be is congenital anomalies, SIDS/SUDI, and short gestation.

Vermont is ranked #3 in its percent of children who are fully immunized. A strong relationship with private providers and comprehensive outreach to families, and high Medicaid coverage aids in achieving this high coverage. The progressive implementation of the Immunization Registry over the next year will positively impact these rates, also.

Vermont child death rate (13/100,000 ages 1-14, 2000 census data) is low, but the activities described in the Title V application and the capacity assessment of the Strengths and Needs Assessment will contribute to preventing needless childhood deaths. Data (from SSDI grant activity) shows that injuries and poisonings are one of the four leading reasons for ED visits for age groups birth to 19. The MCH Planner and the Injury Prevention Coordinator will begin planning for strategies to identify and address public health risk factors associated with this data. Vermont is involved with the pilot project of the MCH Center for Child Death Review which is developing a web-based uniform data base on all child fatalities.

Vermont's prevalence of overweight and obese children is unacceptably high and beginning efforts are being put into place to reduce this condition. Programs via WIC (Fit WIC) and school health are

directed at parent education and referral for children. In addition, other program such as Run Girl Run help children directly to learn about physical fitness and healthy eating. Data is also describing the issue of women of childbearing age who are overweight or obese -- strategies to reach this population are in the planning phases.

Vermont's YRBS indicates a significant drop in the % of students who reported smoking at least once in 30 days. This is especially true across 8th and 10th grades: from 1995 to 2003, cigarette use declined from 41% to 19% among 10th graders and 29% to 11% among 8th graders. Smoking prevalence in the 18-24 age group is 35%, a public health concern as these individuals will begin to become pregnant and form families. Programs in schools, the national QUIT line, and pilot intervention models for physicians offices are strategies to reduce smoking rates. Also, drug and alcohol use in pregnancy is a renewed priority for Vermont. The state is gradually implementing and expanding its offerings of methadone clinic services. Other efforts include the expansion of the Rocking Horse program for pregnant women who use alcohol and investigating funding to plan for the identification and service provision for children affected by prenatal use of alcohol.

Over the past several years, VDH has been able to strengthen its capacity to access and analyze data from several sources, such as vital statistics, Medicaid claims and enrollment data, and hospital discharge data. Grants such as SSDI and Measuring and Monitoring have supported data capacity and planning analysis. The CSHN medical home grant has been instrumental in these efforts also.

B. STATE PRIORITIES

IV. B. State Priorities (refer to the 2005 Strengths and Needs Assessment for discussion of State Priorities for 2005-2010)

1. All children, including those with special health care needs, will receive continuous and comprehensive health services within a medical home.
There are two strategies to achieving this goal, adequacy of insurance, and availability of Medical Homes. Data from the 2001 BISHCA survey indicate that 6,190 (4.2%) Vermont children do not have health insurance. CSHN program enrollment information in 2004 indicates that 20% of children in CSHN programs do not have any insurance, and SLAITS found that 31.3% reported inadequate insurance. CSHN staff encourage and facilitate Medicaid application for CSHN families, but CSHN does not require Medicaid application as a condition for program participation. VT Medicaid offers enrollment through the TEFRA option to children with the most severe disabilities, regardless of family income.
CSHN is in the third year of its collaboration with VT-AAP in implementation of the Medical Home grant. Efforts at developing Vermont's Medical Home capacity are both general to all children, and specific to CSHCN. General capacity efforts include the Office of Rural Health and Primary Care, improving access to underserved populations through building of the rural health care system and strengthening a trained health care workforce. Programs such as Healthy Babies, Kids and Families that work with families with children aged birth to six and Part C assist families in obtaining health and wellness services and to become connected to a medical home. This work on supporting medical home is being incorporated into new collaborative efforts with the Department of Children and Families, such as the ECCS-funded Health Committee of the Building Bright Futures.
Work continues with the Joshua Project in Franklin County (in Northwestern Vermont) to create a community based child development team (I-CAP) to support the role of primary care pediatricians in assessing and care planning for children with developmental concerns. See NPM 3.
2. Youth with special health care needs will receive the services necessary for a

successful transition to adulthood.
SLAITS found that all states scored poorly on this goal. In VT, the indicators which are more directly "medical" appear stronger (doctors have talked about changing needs; doctors discussed shift to adult provider) than interagency measures reflecting collaboration among health, education, and vocational services. Specific plans within CSHN are to update a written agreement with Vocational Rehabilitation; expand the number of CSHN clinics with "adult medicine" collaborators; develop specific age-out activities for CSHN program, and add specific transition planning elements to the VT Medical Home Care Plan models through the activities of the MCHB grant. The AHS reorganization has opened new opportunities to work on this priority with the Department of Disabilities, Aging and Independent Living. See NPM 6.
3. Youth and maternal rates of alcohol and tobacco use will be reduced.
The trends for these two rates show a decline from the previous YRBS data - see SPM 5,6. The 2001 Adult Behavioral Risk Factor Survey indicates that 21% of women report being current smokers and 22% of pregnant women smoke. In addition, 9.3% of women state they alcohol-binge drink, and 1.3 % state they chronically drink alcohol.
The Tobacco Control Program is working with schools and communities on a variety of systems and community based approaches for smoking prevention for youth. Pregnant women in WIC and HBKF are screened for smoking status and offered referral for cessation assistance. Pilot projects (with AHEC) training OB/GYN offices to use a Brief Intervention (BI) model to assist pregnant women smokers - using AHRQ's 5 A's model) Assistance for pregnant women who want to quit smoking via the national Quit Line. Also, nicotine replacement therapy is available to low income women via reimbursement through Medicare or Vermont Health Access Program. In Washington County, a pilot program is being implemented via assistance from a team at Brandeis University. The purpose is to provide TA to obstetricians to assist their pregnant clients who are smokers to quit. Clients will continue to receive support to stay smoke-free via the pediatricians' offices as they bring the infant in for well child care. Prenatal calendar showing fetal development month-by-month distributed to pregnant women via MD's, pharmacies, etc. In Sept 04, airing 2 week radio campaign targeting pregnant smokers called "Baby Translator" from American Legacy - enable tracking of calls from quit line. ADAP also working with prevention activities such as Life Skills Curriculum for school aged children. ADAP is also coordinating with Community Public Health and local community providers on programs that enhance screening and group support sessions for pregnant women who use alcohol. One of these programs, Project Rocking horse, is being expanded throughout the state from its original pilot sites. For the 2005-2010 Title V grant cycle, a new state performance measure will address pregnant women who smoke.

4. All children will receive continuous and comprehensive oral health care within a dental home.
The Dental Health Services of VDH works in concert with dental providers to achieve a system which encourages quality dental care as provided in a dental office where comprehensive continuous care can be achieved. This is the main goal of the Tooth Tutor Program, begun in 1996, provides TA to schools (via trained dental hygienists to provide assessment and referral of students to a local dental home. In 2003/2004, 100 schools participating and able to get over 90% of their students into a dental home, regardless of payer source, including Medicaid. Each year, over 90% of eligible schools participate in the school-based fluoride mouth rinse program. In addition, Dental Health Services continues to assist dentists with grants, loan repayments, and recruitment and retention efforts in order to ensure adequate workforce for a dental home. These programs should serve as an incentive for dental practices to accept more Medicaid patients and for practitioners to view Vermont as a viable state in which to develop dental practices.
In 2003, VDH received a grant from R W Johnson (State Action for Oral Health

Initiatives) to further enhance these strategies of increasing service capacity and access for low income children. Vermont is now engaged in developing a statewide oral health plan working collaboratively with a broad based advisory committee. Strategic action plans from this report will be created at a statewide Oral Health Summit in the Fall of 2005. See also discussion under NPM 9, SPM 2, and HSCI 7.

5. Fetal and infant death rates will be reduced.
VDH, through its many programs and initiatives, focuses on the myriad of risk factors that are associated with poor birth outcomes and infant death, such as inter-pregnancy interval, tobacco use, and pregnancy weight gain. Coordination of program and planning activities is occurring within several
sections of the Vermont Department of Health as well as with statewide partners such as hospital systems, clinical provider associations, Planned Parenthood, March of Dimes, and community based organizations. These efforts include planning for strengthened systems of morbidity and mortality review, provider education and supports for quality improvement in clinical care systems.
SIDS/SUDI program provides trained PHN's for families and community groups for grief counseling and education, linkage to support systems. Also provides training to police groups. emergency responders, and medical personnel. Ongoing public education campaign about Back-to-Sleep and beginning efforts to educates about safe sleep environment. Parents in WIC are asked about their
baby's sleep position (see SPM 4) IN 2003, a mailed survey collected data about counseling practices related to sleep positioning and sleep environment from primary care physicians and hospital nursery nurses. The results are informing statewide education efforts.

6. Injuries and unnatural deaths in children will be reduced.
The Injury Prevention Program: priorities of childhood injuries related to motor vehicle crashes and residential fires described in Vermont Injury Prevention Plan (2002.) Injury surveillance capacity has increased in the following areas (following STIPDA recommendations: ED data sets, development of an injury data matrix, and appropriate assignment of e-codes for injuries. Planning is beginning to address the high numbers of non-traffic motor vehicle crashes and also, increased surveillance caacity id defining the issue for injuries in addition to deaths from crashes. The Suicide Prevention Team is working on a suicide prevention plan for youth: the 2003 YRBS indicates that fewer students have made suicide plans: 13% percent of students made a suicide plan during the previous year, the same number as in 2001, down from 16% in 1999, 18% in 1997 and 22% in 1995. However, the next five year cycle for Title V will monitor the number of teens who have made a plan for suicide as one of the ten state performance measures. The Injury Prevention Plan is partnering with a recently formed (spring, 2004) Deerfield Valley Suicide Education Prevention Committee in southern Vermont and has developed a youth advisory board and is researching the feasibility of establishing a "gatekeepers" training program. The Injury Prevention Program and CPH are revising the Pediatric Periodicity Schedules clinical guidelines on injury risk reduction. The EMS-C grant programs will continue to enhance their system of prehospital data collection. Also, nine regional grants will be awarded statewide for providing community based pediatric emergency care training. EMS-C has partnered with UVM and Fletcher Allen Medical Center to implement a project designed to examine and improve helmet use for the winter sports such as skiing and snowboarding. Healthy Child Care Vermont provides education and curriculum for injury prevention in child care settings. Other surveillance activities: 1) staff have been working with the Chief Medical Examiner to review and clarify issues on identification of injury-related deaths and associated factors, with special emphasis on fire-related deaths, suicide and SIDS/SUDI; 2) participation on a committee developing and implementing a new motor vehicle crash reporting form; 3) preliminary exploration of emergency department data from a new statewide data collection system; and 4) continuation of three injury-related questions added to the Vt BRFSS, two on suicide attempts, one on elderly falls. Working with MCH Center for Child Death Review to pilot web-based

child death review data collection form.

7. Maternal and pediatric exposure to environmental hazards be reduced.
The main areas of focus in protecting maternal and pediatric health and safety due to hazardous exposures in the environment are indoor air quality (carbon monoxide, environmental tobacco smoke, radon, asbestos, and biological pollutants), water quality (lead, copper, nitrates, mercury, and biological contaminants), pesticides (food safety, poisonings), lead and sun safety. These are very broad areas requiring assessment/planning and education of families through dissemination of safety information and coordination of and access to resources for families. Education will be incorporated in home visiting protocols through VDH maternal child programs and via public education campaigns. Coordination between VDH and the Agency of Natural Resources for educational efforts to providers and the MCH population about the hazards of mercury in fish: /2005/ updated Mercury in Fish posters/brochures being finalized and to be distributed statewide. Proposed question to BRFSS on tuna consumption in women of childbearing age. Re; school health, the ENVISION program provides training and materials to schools who commit to implementing an environmental health policy and management plan, ie; addressing issues such as indoor air quality, etc. In 2004, 9 schools were recognized for their work with ENVISION program. In 2003, 68% of 1 year olds and 13% of two year olds were tested for Lead exposure. Of those tested, 5% of 1 year olds and 9% of two year old had an elevated BLL. The Childhood Lead Poisoning Prevention Program continues to work to further reduce these rates and to increase the numbers of children screened. CLPPP collaborates with clinical providers and the AAP to expand its clinical lead screening and home assessment services for families with young children. In addition, the VDH works closely with landlords and municipal staff to assist in lead reduction activities. In FFY03, planning began for the public health response for events of attacks on the public safety - such as biological or chemical - see discussion in III. A. Overview.

8. The rates of unintended and adolescent pregnancies will be reduced.
A wide variety of services exist for many strategies to continue the reduction in these rates, such as the VDH/HBKF, PCC, DCF, PPNNE, and Dept of Ed. The VDH continues to coordinate needs assessment and program activities, such as working through each counties' MCH Coalition. See discussions in NPM 8, Overview and Priorities.

9. Families with CSHN will have access to individualized, comprehensive home and community based support services.
Addresses the particularly critical shortage of home-based services for children with special health needs, such as trained nurses and personal care attendants. Under a new Medicaid option, families may choose to recruit and employ their child's care attendant directly, eliminating a middleman agency, and increasing modestly the hourly wage. The joining of the hi-tech program with Personal Care Services and Developmental Services in a new department may focus new energy on addressing this issue.

10. The prevalence of childhood overweight/obesity will be reduced.
The Governor's Initiative is supporting many activities to address overweight and obesity (IIIA Overview/Priorities, SPM 10) The VDH Run Girl Run program, designed to increase physical activity, build self esteem, and reduce risk taking behavior in girls aged 8-14, is able to expand due to 2004 new state funding. VDH and Education are developing programs and curricula on nutrition and physical activity, such as the National Health Education Assessment Project. A state plan for obesity prevention is being developed. WIC program educates familes overweight kids, Fit WIC, Play Every Day Activity Kit. CDC grant to coodinate overweight prevention activities. New

planning for overweight women.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	99	99	99.5	99.9	99
Annual Indicator	96.3	99.0	100.0	100.0	100.0
Numerator	6041	6086	8	5	3
Denominator	6272	6149	8	5	3
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	99.5	99.5	99.5	99.5	99.5

Notes - 2002

The denominator is the number of newborns screened and confirmed with conditions mandated by the state sponsored newborn screening program. The numerator is the number of newborns screened and confirmed with conditions mandated by the State sponsored newborn screening program who received appropriate follow-up as defined by the state. Note that in previous years, Vermont has reported the denominator as the numbers of all occurrent births, not just those newborns with a positive screen. Thus, there is an obvious difference in the numerators and denominators for 2002.

Notes - 2003

The denominator is the number of newborns screened and confirmed with conditions mandated by the state sponsored newborn screening program. The numerator is the number of newborns screened and confirmed with conditions mandated by the State sponsored newborn screening program who received appropriate follow-up as defined by the state.

Notes - 2004

Vermont continues to have a very high rate of metabolic screening for newborn infants. The Screening Panel was increased to 21 conditions; additional disorders may be requested by the physician. It is important to note that identified cases include not only VT newborns, but also out of state births screened in VT, transfers, refugees and adoptees.
The New England Screening Laboratory continues to perform the "Vermont Panel" on any Vermont births who are transferred to and tested in New Hampshire, Maine, Massachussetts, or Rhode Island.
Infants born in Vermont but transferred out of state without screening are identified via birth certificate lists and/or through hospital birth lists and follow up for screening is insured by NBS Program Chief.

The denominator is the number of newborns screened and confirmed with conditions mandated by the state sponsored newborn screening program. The numerator is the number of newborns screened and confirmed with conditions mandated by the State sponsored newborn screening program who received appropriate follow-up as defined by the state.

a. Last Year's Accomplishments

Vermont continues to have a very high rate of metabolic screening for newborn infants. The Screening Panel was increased to 21 conditions; additional disorders may be requested by the physician.

The Metabolic Screening program insures that Vermont infants who are transferred soon after birth to an out-of-state hospital are screened and receive the necessary follow up.

The program coordinates with out-of-state metabolic screening programs on infants who are Vermont residents and born out-of-state and need a repeat screen.

Family refusal is performed by "informed dissent" and parents sign a form acknowledging they have been counseled about the intent of the screens and potential health issues if conditions are not detected at birth.

VDH provides TA to birth hospitals to insure quality and compliance with current standards of practice.

NBS services are provided via contracts with Fletcher Allen Health Care and U Mass Medical Center.

A nurse who has long been involved in newborn hearing activities (principally hearing) has retired.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to operationalize the newly implemented newborn screening panel. As a result of the expanded panel, several associated activites are continuing such as: professional education, development of clinical mangagement protocols, creation of educa			X	X
2. Consider addition of cystic fibrosis screening.			X	X
3. Continue program activities to ensure that all infants are screened or are offered screening and that no infant is "missed or lost to follow up" as well as general NBS program operations: program development, maintenance of records, follow up out-of-			X	X
4. Continue cross-border NBS and UNHS collaboration efforts.			X	X
5. Analyze costs of NBS and UNHS and develop methods for program self-support through fees, EPSDT, and Title V.			X	X
6. Recruit and hire new fulltime nurse.				X
7.				
8.				
9.				

10.

b. Current Activities

As above.
On November 1, 2003, Vermont implemented an expanded newborn screening panel of 21 conditions for all infants born in the state.
Of 6260 VT occurrent births in 2004, 13 died without screening; 6247 were eligible for screening. 6175 (98.85%) VT births were screened in VT; 27 VT births were screened out of state (0.43%). 45 (0.72%) refused screening. 99.28% of the total eligibles were screened in VT and/or out of state. Three were confirmed and treated for congenital hypothyroidism. One case of Duarte variant galactosemia was confirmed and treated appropriately. 39 hemoglobinopathies were confirmed; none needed treatment. 12 cases of sickle cell trait were identified. It is important to note that these identified cases might include not only VT newborns, but also out of state births screened in VT, transfers, refugees and adoptees (denominator = 6346, not 6260).
The New England Screening Laboratory continues to perform the "Vermont Panel" on any Vermont births who are transferred to and tested in New Hampshire, Maine, Massachussetts, or Rhode Island.

Infants born in Vermont but transferred out of state without screening are identified via birth certificate lists and/or through hospital birth lists and follow up for screening is insured by NBS Program Chief.

General NBS program operations continue to be program development, maintenance of records, follow up out-of-range screenings, physician/parent referrals to specialty services, statistical reporting, TA to hospitals, laboratories.

c. Plan for the Coming Year

Continue to operationalize the newly implemented newborn screening panel. As a result of the expanded panel, several associated activites are continuing such as: professional education, development of clinical mangagement protocols, creation of educational materials for professionals and families.

Consider addition of cystic fibrosis screening.

Continue program activities to ensure that all infants are screened or are offered screening and that no infant is "missed or lost to follow up" as well as general NBS program operations: program development, maintenance of records, follow up out-of-range screenings, physician/parent referrals to specialty services, statistical reporting, TA to hospitals, laboratories.

Continue cross-border NBS and UNHS collaboration efforts.

Analyze costs of NBS and UNHS and develop methods for program self-support through fees, EPSDT, and Title V.

Recruit and hire new fulltime nurse.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				57.4	57.4
Annual Indicator			57.4	57.4	57.4
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	57.4	60	60	60	60

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS. As described in the narrative, the SLAITS data emphasizes the physician's role as partner, and is not specific to particular "services." Finding a suitable proxy measure for the SLAITS indicators, in the interim years, will be difficult for VT, as for all states.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

> We continued to include family centered care goals in grant/contract work specifications.

> With the Medical Home grant, we analyzed and applied the information gleaned from the family focus groups on satisfaction with medical homes and services such as CSHN.

We continue to provide substantial infrastructure support to two parent-run organizations, Parent to Parent of Vermont (P2P), and the VT Parent Information Center (VPIC).

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Continue expectation of family centered care in grant/contract language.	**X**	**X**		**X**
2. Continue regular meetings with P2P and VPIC leadership				**X**
3. Re-establish regular meetings of CSHN Family Advisory Council				**X**

4. Apply information gathered from focus groups and PCP/Specialist surveys to CSHN systems.	X	X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

> As above.

See Strenghths and Needs Assessment.

We have begun regular meetings with the leadership of P2P and VPIC, for parent input.

c. Plan for the Coming Year

Continue expectation of family centered care in grant/contract language.

Continue regular meetings with P2P and VPIC leadership

Re-establish regular meetings of CSHN Family Advisory Council

Apply information gathered from focus groups and PCP/Specialist surveys to CSHN systems.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective				56.5	56.5
Annual Indicator			56.5	56.5	56.5
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	56.5	60	60	60	60

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS. In past years, VT has approximated this indicator utilizing the percentage of parents who report that their child has a regular primary care provider, upon enrollment in a CSHN program, supplemented by occasional focus group discussions around this and other systems issues. The SLAITS figure is similar to the percentage of parents in focus groups who reported care in a Medical Home, and is much lower than the percentage of CSHN children who have primary care providers. In the intervening years (before the next SLAITS), we will not be able to replicate the SLAITS measures. Instead, we will look at the PCPs named by CSHN families and compare with the expanded participation of practices in our medical home project, to arrive at an estimate of CSHCN receiving care in medical homes. There are drawbacks to this method, however. Because the medical home is about relationships, different families experience different relationships with the same PCP. In addition, the lack of outward trappings of a medical home (such as a paid care coordinator) does not necessarily mean that the same outcomes cannot be achieved.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure. In addition, in our focus groups for this year's Needs Assessment , only 15% identified their PCP as central to their CSHCN's overall care; 44% said the PCP provided little or no care coordination; 59% said their PCP provided little or no information. However, significantly, 98% said they, as parents, wanted TOTAL CONTROL and FULL RESPONSIBILITY themselves, not the PCP.

a. Last Year's Accomplishments

Last Year's Accomplishments:

In March 2005 CSHN completed its three-year MCHB-funded medical home project.

At the end of the reporting year we planned (and, in 2005, successfully completed) application for the NICHQ Medical Home Learning Collaborative-II, involving the Title V program and 3 practices.

We implemented a pre-visit form by which the PCP communicates with the Child Development Clinic team the specific concerns and questions for the visit, and a fax-back form after clinic.

We disseminated guidelines to PCPs for the follow-up audiologic diagnosis of babies suspected of hearing loss.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Complete participation in the NICHQ-MHLC-II successfully	X	X		X
2. Achieve consistent, improved reimbursements for PCP care plans for CSHCN under Medicaid	X	X		X
3. Improve PCP information in the CSHN patient database				X
4. Apply focus group feedback to PCP/CSHN relationships.	X	X		X

5. In interagency discussions planning care coordination projects, advocate for the PCP-based medical home model for CSHCN.	X	X		X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

See Strengths and Needs Assessment

We continue to work with VCHIP, Medicaid, and AAP on improving Medicaid reimbursement for medical home activities (care plans; incident-to billing)

we are participating with NICHQ-MHLC-II for one year, supporting three practices in their PDSA cycles to implement certain medical home strategies.

> We continue to focus on understanding the essential niche for Child Development Clinic in the changing health care environment, in internal and external conversations, especially on its collaboration with PCPs and community-based services.

c. Plan for the Coming Year

Complete participation in the NICHQ-MHLC-II successfully

Achieve consistent, improved reimbursements for PCP care plans for CSHCN under Medicaid

Improve PCP information in the CSHN patient database

Apply focus group feedback to PCP/CSHN relationships.

In interagency discussions planning care coordination projects, advocate for the PCP-based medical home model for CSHCN.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				68.7	68.7
Annual Indicator			68.7	68.7	68.7

Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	68.7	72	72	72	72

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS. The SLAITS figure is lower than the percentage of children enrolled in CSHN who have a source of insurance (84.5%, see Form 7). However, the SLAITS outcome includes three indicators of family perception of adequacy of insurance. On the other hand, the SLAITS question about insurance at the time of the interview was positive for 97% of VT families. In the interval before the next SLAITS, we will continue to use the percentage of families reporting insurance.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure. However, please also see the data on Form 7 which indicates a higher percentage of insurance coverage for children with whom we work through our CSHN programs.

a. Last Year's Accomplishments

Last Year's Accomplishments:

> CSHN continues to identify families who might be eligible for Medicaid and encourage and support them in the application process.

> CSHN continues to call attention to the potential negative impact of the new and expanded Medicaid premiums, and to work toward the resolution of concerns around Medicaid enrollment and benefits for CSHCN

CSHN hired a pediatric PT to work on a variety of policy and direct service issues, including appropriate prescriptions and prior authorizations.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue efforts to increase Medicaid enrollment for CSHCN		**X**		**X**
2. Continue policy dialogue with Medicaid around interpretation of policy for CSHCN.				**X**
3. Improve methods to identify families who are losing their Medicaid coverage for non-payment of premiums and find strategies to keep their Medicaid coverage continuous.				**X**
4.				

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Current Activities:
> As above, and
Continue vigilance around third party benefits for CSHN, such as medical necessity interpretations.

c. Plan for the Coming Year

Continue efforts to increase Medicaid enrollment for CSHCN

Continue policy dialogue with Medicaid around interpretation of policy for CSHCN.

Improve methods to identify families who are losing their Medicaid coverage for non-payment of premiums and find strategies to keep their Medicaid coverage continuous.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective				72.7	72.7
Annual Indicator			72.7	72.7	72.7
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	72.7	75	75	75	75

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS, and is based on family response to only one question, perception of ease of use of services. In the interval before the next SLAITS, we will look at measures of geographic access to services (such as SPM#3) and measures of access to service coordination (such as NPM#3) as proxies for this outcome.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure. Among the parents who participated in our Needs Assessment focus groups, 81% said that they have access to all needed services for their CSHCN.

a. Last Year's Accomplishments

> Initially with SPRANS support, CSHN expanded clinical nursing and social work staff to the 12 regions of the state, serving 12 from sites now in 10 regions. Several clinics travel to sites around the state.

> CSHN continues to support a multidisciplinary team approach to care, including care coordination.

> Because of critical shortages in child psychiatry services, CSHN continues to contract with a child psychiatrist with special expertise in children with disabilities, to provide consultation to CSHN teams and short term direct services, emphasizing return of care to the primary care physician when the child is stable.

> Flexibility in policies, access to agency-level decision-makers, utilization of special funds, and above all, family priorities as the driver of the support systems, are essential strategies.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increase number of regional sites (now 10) serving the 12 regions, for care coordination.		X		X
2. Continue multi-site clinics, for geographic access.	X	X		X
3. Add at least one new CDC regional site.	X	X		X
4. Improve collaboration with expanded regional P2P staff.		X		X
5. Continue to participate vigorously in AHS planning for improved care coordination systems, with focus on CSHCN.				X
6. Continue to support child psychiatry consultation for CSHN who have developmental or chronic conditions as well as mental health needs.	X			X
7.				
8.				
9.				
10.				

b. Current Activities

See SNA

As above.

In addition, this year, we have stabilized funding support for the medical social worker based in a region (St. Albans) where CSHN has not located direct staff time before. Originally funded by CATCH funds, the MSW now supports CSHN children and families living in the area, as well as staffing the region's Part C team, and is co-located part time with the area's largest PCP practice.

c. Plan for the Coming Year

Increase number of regional sites (now 10) serving the 12 regions, for care coordination.

Continue multi-site clinics, for geographic access.

Add at least one new CDC regional site.

Improve collaboration with expanded regional P2P staff.

Continue to participate vigorously in AHS planning for improved care coordination systems, with focus on CSHCN.

Continue to support child psychiatry consultation for CSHN who have developmental or chronic conditions as well as mental health needs.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective				5.8	5.8
Annual Indicator			5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.8	7.5	7.5	7.5	7.5

Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted. In VT, the focus will be on improving the medical team planning for adult medical services and the transition to adult attendant care services, where appropriate.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure. We hope to be able to review the percentage of adolescents with Medicaid who have had an annual care plan paid by medicaid, compared to younger children and compared over time. Only CSHCN are able to have care plans paid for.

a. Last Year's Accomplishments

CSHN director participated (and continues) in the search committee for a second pediatric orthopedist.

CSHN staff received training/information from programs with focus on youth transition, including vocational rehabilitation, special education across the transition, and changes in Medicaid coverage at age 18.

AHS reorganization interrupted some interagency "policy clusters" around CSHCN and YSHCN, but these have recently resumed with a focus on personal care attendants and high-tech nursing in the home; the CSHN director is a key participant.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Pursue the possibility of including a pediatric physiatrist in CSHN clinics/programs	X			X
2. Continue work with interagency committees (see above).				X
3. Add adolescent transition plans to CSHN clinic practices, beginning with Craniofacial and Myelomeningocele.	X	X		X
4. Develop method to monitor Medicaid billings for care plans for adolescents.		X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Last Year's Accomplishments:

See SNA.

As above; and,

> Continuing to recruit and interview for a second pediatric orthopedist.

Continuing staff trainings.

c. Plan for the Coming Year

Pursue the possibility of including a pediatric physiatrist in CSHN clinics/programs

Continue work with interagency committees (see above).

Add adolescent transition plans to CSHN clinic practices, beginning with Craniofacial and Myelomeningocele.

Develop method to monitor Medicaid billings for care plans for adolescents.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	90	90	90	90	90
Annual Indicator	86.2	78.8	80.9	84.3	83.2
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	90	90	90

Notes - 2002

Data is for FFY 02 and is from NIS statistics - actual numerators and denominators are not available. Data for FFY 01 and FFY 02 reflects the 4:3:1:3:3 schedule. Previous years reflect the 4:3:1:3 schedule.

Notes - 2003

Data is from NIS and is for July, 2002 to June, 2003. Percentage is recorded - actual numerators and denominators are not available. Data for 2001, 2002, and 2003 reflect the

4:3:1:3:3 schedule. Previous years reflect the 4:3:1:3 schedule.

Notes - 2004

Data is from NIS for July, 2003-June, 2004. Reflects the 4:3:1:3: schedule. The percentage is entered - the acutal numerator and denominator are not available.

a. Last Year's Accomplishments

> District Offices held monthly iz clinics, based on local demand. All 12 offices, as staffing permits, schedule immunizations based on the clients/family needs. Our intervention primarily comes when there are barriers to accessing the medical home, such as not having medical insurance. Families contacted by phone/letter when due for next Iz.
> Some Vermont practices do not carry varicella vaccine, so to accommodate the community the District Office can carry varicella.
> It is expectation that all nurses working for VDH will routinely administer age-appropriate vaccine according to accepted protocol and with parental informed consent.
> Primary Care Providers are notified of immunization(s) given at the District Office.
> Vaccines are provided free according to the current Vermont Vaccine Availability. There was no charge for the vaccine or the administration of these immunizations, when administered by nurses working for the VDH. July 1, 2003 Vermont became a universal state.
> Iz screening and follow up was conducted routinely for all children seen in WIC clinics. Follow up services included assistance in locating a regular health care provider, obtaining the child's most current immunization record from their primary care provider, in understanding Medicaid benefits related to immunization, and transportation assistance. When needed, vaccines were administered through the VDH District Office and the information is shared with the Primary Care Provider.
> Wide distribution of a one page "Have Your Tots Had all their Shots" flyer, features a simplified immunization schedule and a toll free phone number to reach VDH Iz Program for more information.
> Post cards with the 2002 and 2003 immunization schedule mailed to Medicaid parents at 3 months, 8 months, and 20 months reminding them their child was due for immunizations.
> VDH works with Refugee Resettlement to facilitate Iz and informed consent for refugees.
> Distributes Path to Parenthood to all pregnant mothers - includes section on Iz.
> 2002 - Growing Up Healthy, new publication with information on Iz, is distributed to all parents while still in hospital after birth of baby.
> Coordinate with Child Care programs to notify parents when their child is due for Iz. Overall data gathering to assess levels of Iz for children enrolled in day care.
> Using CASA software, assess 2 year olds in VDH programs - identify and inform parents if their child needs Iz.
> VDH staff stay informed on Iz topics via a variety of methods, including distance learning (CDC and California DL Health Network)
> DO's have worked on populating the Iz registry with information about the children who are enrolled in Iz-related programs. As of 12/03, all 12 district offices have been connected to the Iz registry. Many offices have been able to populate the registry with a large percent of their children who are enrolled in WIC.
> As of December, 2003, 17 sites were enrolled in the Iz registry- 5 private practices and 12 VDH DOs.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue process of establishing Immunization Registry - population with data and expanding participation of providers and also begin expansion to schools.			X	X

2. Enhancements for Immunization registry software			X	X
3. Continue with local immunization clinical services and familiy referral to medical home	X	X		
4. Continue assessment of local services capacity		X		
5. Continue Vermont vaccine program services		X	X	X
6. Plan for wide distribution of flu vaccine to children in 2005-2006	X	X		
7. Continue distribution of "Have your tots had all their shots" flyers	X	X		
8. Continue with strategies for parent education activities, such as EPSDT informing letters and education at birth hospitals.	X	X		
9. Continue collaboration with state child care facilities	X	X		
10.				

b. Current Activities

> Continue with activities from last year's accomplishments

> EPSDT staff have designed new EPSDT Informing Letters which are based on input from enrolled families. These letters inform families of the benefits to which Medicaid-enrolled children are entitled, including immunizations. The letters are colorful, personalized to the child's name and include age-appropriate information about upcoming health supervision needs and anticipatory guidance. They are mailed out annually to each enrolled child and offer the assistance of the local VDH District Office in helping the family access primary care or other related services.
> 20,000 doses of influenza vaccine were distributed for Vermotnt children during the 2003-2004 flu season (13,500 doses were distributed for 2002-2003.) The great majority of doses were administered in both public and private settings.
> Contract awarded to Vermont Child Health Improvement Program to do outreach, recruitment, and provide TA to private practices for the Iz registry.
> Contracted with a technical writer to review and edit the Immunization Registry User Manual and to develop a quick-reference two page instruction sheet.
> Vermont is the only state building a registry that is using the NEDSS model - staff have presented at two national conferences about the process.

c. Plan for the Coming Year

> Continue with activities from last year's accomplishments
> VDH staff will continue to populate Iz registry with information from program records, such as WIC.
> Iz registry to continue plans to expand the registry via recruitment of providers and further development of the data base and technical systems. Goal is for 50-75 sites by December, 2004 and to bring on an additional 50 provider sites in 2005.
> For 2005-2006, to concnentrate on working with school nurses to bring i schools as participating sites.
> For CY 2005, concentrate on identifying new enhancements for the registry software, creating standard reports, and working to improve the data quality. Also to investigate options for importing immunization data from other sources such as insurers, billing systems, Medicaid, etc.
> Continue with wide distribution of flu vaccine for children.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	14.8	10	10	10	10
Annual Indicator	10.4	11.2	10.2	6.7	
Numerator	137	136	136	88	
Denominator	13175	12158	13397	13208	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6	6	6	6	6

Notes - 2002
The data to calculate this measure for 2002 are currently not consistently available, but will be available at the end of the 2003 calendar year.

Notes - 2003
The data to calculate this measure for 2003 are currently not consistently available, but will be available at the end of the 2004 calendar year.

Notes - 2004
The data to calculate this measure for 2004 are currently not consistently available, but will be available at the end of the 2005 calendar year.

a. Last Year's Accomplishments

> Priority is given to outreach to pregnant teens and their families including: home visits, classes and support groups, transportation to medical appointments, labor support as needed, support with educational needs.

> The Addison County Parent Child Center focuses on education and support around risky behaviors and pregnancy prevention, in particular targeting high risk teens (both male and female). This is done within the public school environment as well as with teens who utilize PCC services, e.g., teens who have a negative pregnancy test.

> Teens enrolled in HBKF are strongly encouraged to finish high school or their G.E.D. and given support for prevetion of second pregnancy.

> Coordination with organizations such as Parent Child Centers, Department of Education, and Planned Parenthood to support prevention programs education efforts directed at teens adn teens considered "at-risk"

> Coordination with VCHIP, AAP, AHS, and Department of Education on broad prevention efforts using Assets-based approach to working with teens and their families.

> Support for community and state wide activities to postpone subsequent pregnancies due to

higher infant morbidity and mortality rates when pregnancies occur in younger women (15-18) and are spaced less than two years apart.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Target high risk teens for prevention and intervention services via HBKF	X	X		
2. Coordination with prevention and intervention activities of community based programs		X		
3. Continued surveillance and analysis of relevant population based measures and also program based data.				X
4. Support broad based prevention activities with Dept of Education, Planned Parenthood, Parent Child Centers, etc.	X	X		
5. Collaborate with HBKF and Dept of CHildren and Families for continuing public health and prevention focus in programs.	X	X		
6. Coordinate with VCHIP, AAP, AHS and Dept of Ed on prevention activities using assets based framework.		X		
7. Support physical exercise programs initiatives (via Coordinated School Health and Run Girl Run) to build esteem and educate about the importance of personal health and fitness.	X	X		X
8.				
9.				
10.				

b. Current Activities

> Priority is given to outreach to pregnant teens and their families including: home visits, classes and support groups, transportation to medical appointments, labor support as needed, support with educational needs.

> The Addison County Parent Child Center focuses on education and support around risky behaviors and pregnancy prevention, in particular targeting high risk teens (both male and female). This is done within the public school environment as well as with teens who utilize PCC services, e.g., teens who have a negative pregnancy test.

> Teens enrolled in HBKF are strongly encouraged to finish high school or their G.E.D. and given support for prevetion of second pregnancy.

> Coordination with organizations such as Parent Child Centers, Department of Education, and Planned Parenthood to support prevention programs education efforts directed at teens adn teens considered "at-risk"

> Coordination with VCHIP, AAP, AHS and Department of Education on broad prevention efforts using Assets-based approach to working with teens and their families.

> Support for community and state wide activities to postpone subsequent pregnancies due to

higher infant morbidity and mortality rates when pregnancies occur in younger women (15-18) and are spaced less than two years apart.

c. Plan for the Coming Year

> Priority is given to outreach to pregnant teens and their families including: home visits, classes and support groups, transportation to medical appointments, labor support as needed, support with educational needs.

> The Addison County Parent Child Center focuses on education and support around risky behaviors and pregnancy prevention, in particular targeting high risk teens (both male and female). This is done within the public school environment as well as with teens who utilize PCC services, e.g., teens who have a negative pregnancy test.

> Teens enrolled in HBKF are strongly encouraged to finish high school or their G.E.D. and given support for prevention of second pregnancy.

> Coordination with organizations such as Parent Child Centers, Department of Education, and Planned Parenthood to support prevention programs education efforts directed at teens adn teens considered "at-risk"

> Coordination with VCHIP, AAP, AHS and Department of Education on broad prevention efforts using Assets-based approach to working with teens and their families.

> Support for community and state wide activities to postpone subsequent pregnancies due to higher infant morbidity and mortality rates when pregnancies occur in younger women (15-18) and are spaced less than two years apart (Supportive role of Infant Mortaltiy Committee)

> Continue to work with schools and the communities to provide esteem building and future directed programs for teenage girls.

> Support physical exertion initiatives eg Fit WIC, Coordinated School Health and Fit and Healthy Kids to build esteem and educate importance of personal health.

> Coordinate with new AHS Department of Children and Families to maintain pregnancy prevention theme in planning prevention programs for children and adolescents.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	50	50	50	67	68
Annual Indicator	43.3	9.0	66.3	66.3	66.3
Numerator	1314	347	271	271	271

Denominator	3038	3875	409	409	409
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	69	70	71	72	72

Notes - 2002

Data on all third grade children are not available for this measure. In the past, data have been derived from interpolations of Medicaid sealant application figures or from Medicaid claims data. This year's data is taken from a one time, non invasive screening of 1,238 children in grades 1 - 3. The screening and referral project was supported by a grant from the Vermont state legislature.

Notes - 2003

Data for 2003 are the same as for 2002, which is from a one time non invasive screening of 1,283 children in grades 1-3. No new data is available which would be considered more accurate or complete than the survey data.

Notes - 2004

Data for 2004 are the same as for the two previous years. Data are from a one-time, non-invasive, screening of 1,283 children in grades 1-3. No new data are available which would be considered more accurate or complete than these survey data.

a. Last Year's Accomplishments

Last Year's Accomplishments:
> Ongoing collaboration with EPSDT for dental outreach and access to care activities.

> Ongoing collaboration with Tooth Tutor (school-based , facilitates referral to dental home) and fluoride programs (school-based and community water systems). Expansion of these programs as capacity and funding allows.

> Published report of the oral health survey of 2002-2003. Distributed widely to clinicians, schools and other organizations concerned about children's oral health needs.

> Begin participation in Oral Health Advisory Committee and the process for creating a statewide oral health strategic plan.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Follow up with newly released state oral health plan with strategies that influence this measure - such as outreach and informing and also increasing access to dental home.		**X**	**X**	**X**
2. Continue work of Tooth Tutor (school based) to enhance ability of children to receive sealants and also access medical home.		**X**	**X**	**X**
3. Continue outreach to families via Medicaid and EPSDT		**X**		
4. Continue public media campaign re: importance of preventative oral hygiene care		**X**		

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

> Ongoing collaboration with EPSDT for dental outreach and access to care activities.

> Ongoing collaboration with Tooth Tutor and fluoride programs (school-based and community water systems). Expansion of these programs as capacity and funding allows.

> Planning of statewide Oral Health Summit in Fall, 2005.

> Creation of State Oral Health Advisory Committee and the writing of the Oral Health Plan

c. Plan for the Coming Year

> Ongoing collaboration with EPSDT for dental outreach and access to care activities.

> Ongoing collaboration with Tooth Tutor and fluoride programs (school-based and community water systems). Expansion of these programs as capacity and funding allows.

> Participation in creation of the Vermont Oral Health Strategic Plan and offer recommendations for addressing the need for children to receive protective dental sealants.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	4	4	3	3	3
Annual Indicator	2.5	1.6	NaN	NaN	NaN
Numerator	3	2	0	0	0
Denominator	120487	127292	0	0	0
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**

Annual Performance Objective	2	2	2	2	2

Notes - 2002

Following the procedures outlined in Technical Note IX, Guidelines for Calculating Performance Measures using Small Samples, null values are entered here in lieu of a rate. In 2002, 2 children aged 14 or younger died due to motor vehicle crashes in Vermont, a number below the threshold for which rates are to be calculated.

Notes - 2003

Following the procedures outlined in Technical Note IX, Guidelines for Calculating Performance Measures using Small Samples, null values are entered here in lieu of a rate. In 2003, 3 children aged 14 or younger died due to motor vehicle crashes in Vermont, a number below the threshold for which rates are to be calculated.

Notes - 2004

Data for 2004 is not yet consistently available and therefore we are using 2003 data as a rough approximation of the situation in 2004.

Following the procedures outlined in Technical Note IX, Guidelines for Calculating Performance Measures using Small Samples, null values are entered here in lieu of a rate. In 2003, 3 children aged 14 or younger died due to motor vehicle crashes in Vermont, a number below the threshold for which rates are to be calculated.

a. Last Year's Accomplishments

> As part of KISS (Kids in Safety Seats) Program, VDH car seat technicians provide one-on-one instruction to families on appropriate installation and use of child safety seats and distribute subsidized safety seats to low income families. In 2003 - 2004, this training was begun to be phased out as a result of state budget cuts and demands for redistribution of staff resources. Continue to provide information about local safety seat inspections to VDH clients.

> Coordination within VDH and state government and community organizations on car safety issues, such as between VDH (Injury Prevention Advisory Committee, HI, CPH) Governor's Highway Safety Council, Child Fatality Review COmmittee, etc.

> Improved surveillance activities such as working with Vt Association of Hospitals and Health Systems for ED data gathering. Continuing to develop the injury surveillance plan.

> VDH staff provide public education (along with Governor's Highway Safety and Dept of Education) about the newly passed occupant safety law which takes effect January, 2004.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Distribution of safety seat use information in WIC and HBKF	X			
2. Provide education about Vermont safety belt laws to the public via flyers and other education strategies.		X		
3. Continue with mortality surveillance via VDH Injury Prention Program and Child Fatality Review Committee.				X

4. Continue development of the Injury Surveillance Plan				X
5. Continue collaboration with Governor's Safety on programs for public education about crash prevention and safety belt use.			X	
6. Planning wiht Dept of Ed and Governor's Safety for education of parents of teen drivers (strategies on how to teach a teen how to drive)			X	
7. Continue planning for participation in web-based Uniform Death Review system.				X
8. Continue collaboration with Child Fatality Review Committee				X
9.				
10.				

b. Current Activities

> Coordination within VDH and state government and community organizations on car safety issues, such as between VDH (Injury Prevention Advisory Committee, HI, CPH) Governor's Highway Safety Council, Child Fatality Review COmmittee, etc.

> Planning for the development and implementation of the Uniform Child Death Review web-based data form - use of this form will assist in gathering more complete information on associated factors involved with car crashes.

> Coordination within VDH and state government and community organizations on car safety issues, such as between VDH (Injury Prevention Advisory Committee, HI, CPH) Governor's Highway Safety Council, Child Fatality Review Committee, etc.

> Continue to develop the injury surveillance plan and surveillance capacity.

c. Plan for the Coming Year

> Coordination within VDH and state government and community organizations on car safety issues, such as between VDH (Injury Prevention Advisory Committee, HI, CPH) Governor's Highway Safety Council, Child Fatality Review Committee, etc.

> Reexamine other opportunities for collaboration with the Governor's Highway Safety Program, such as with car crash prevention and, specifically, in education of parents as they instruct their teen children on driving techniques.

> Continue planning for the implementation of the web-based uniform child death review form. Pilot to be in January, 2005.

> Implementing of the statewide injury surveillance plan.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004

Annual Performance Objective	61	63	77	78	79
Annual Indicator	75.2	76.8	78.6	79.9	
Numerator	4722	4724	4800	5028	
Denominator	6280	6150	6107	6291	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	82	82	83	84	85

Notes - 2002

The data to calculate this measure for 2002 are currently not consistently available, but will be available at the end of the 2003 calendar year.

Notes - 2003

Denominator reflects Vermont occurent births. Data source is birth certificates.

Notes - 2004

The data to calculate this measure for 2004 are currently not consistently available, but will be available at the end of the 2005 calendar year.

a. Last Year's Accomplishments

Progress Toward Goal of 75% initiation rate and 45% for at least six weeks.
> Breastfeeding initiation rate among WIC participants continued a slow, steady rise. Data from 2000 CDC PNSS shows breastfeeding initiation rate of 60.9%, up from 60% the previous year. While we still have far to go to reach the 75% goal, we have made significant gains in the past 6 years - the breastfeeding initiation rate in 1994 was 45%.
> We met the 45% goal for breastfeeding duration of at least 6 weeks, with 20.1% of infants exclusively breastfed at the 6 week visit and another 29.3% receiving mixed feeds.
> PedNSS data (2001) showed that 29% of infant and child WIC participants were breastfed for at least 6 mo, and 25% were breastfed for at least 12 mo. The comparable national figures are 21% at 6 mo and 12% at 12 mo.
> Breastfeeding Friendly Employer Project - developed Breastfeeding Friendly Employer Designation.
> Purchased/distributed manual and pedal pumps statewide. For women who have established milk supply, who are returning to work or school and who are motivated to continue breastfeeding. In FFY 2002, distributed 89 pedal pumps.
> Electric Pump Rental - expanded last year's rental contract pilot project statewide, making electric breast pumps available to lactating women who are returning to work or school and desire to continue breastfeeding their infants. Also provides electric breast pumps to lactating women who are in medical need that is not considered by their insurance providers to require a breast pump. The rental station bills the state directly, at a pre-determined monthly rate. So far, 170 women have used the program.
> Best Start Conference held in 2002 for training community and VDH staff in the national Loving Support campaign. Granted funds for a Loving Support breastfeeding promotion campaign in 2003.
> Ongoing local activities of Breastfeeding Coalitions
> Develop local resource guides
> Develop pumping stations in VDH office buildings and sites.
> Breastfeeding classes at VDH offices

> Training sessions for professionals
> Local agreements to make electric pumps available for WIC clients
> Annual activities for World Breastfeeding Week, including proclamation from Governor.
> 37 employers recognized as "breastfeeding friendly"
> Peer Counseling - The national WIC program has made a very small amount of funds available for developing breastfeeding peer counselor programs for WIC participants. Vermont staff attended training on establishing and managing a peer counselor program in June 2004.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue with WIC general activities for promotion of breastfeeding with mothers and families	X			
2. Continue ongoing VDH community and staff training		X		
3. Continue local support/coodination of breastfeeding coalitions		X		
4. Continue with WIC pump rental program	X			
5. Continue with activities to promote breastfeeding friendly employer program	X	X		
6. Continue maintenance of VDH website wiht breastfeeding information	X			
7. Continue Loving Support grant activities	X	X		
8. Continue coordination between VDH and breastfeeding advisory committee		X	X	
9. Ongoing community and state celebrations of World Breastfeeding Week	X	X		
10. Continue planning of peer counseling demonstration project	X	X		

b. Current Activities

> Ongoing activities as described above.
> Building Bright Futures: Vermont's Alliance for Children. Much work is being done to build a unified system of early care, health and education for families with young children that ensures children are ready for school. We can begin to make state and local connections among the early childcare community, Kids Are Priority One Campaign and the business community to promote economic development and increase worker productivity that include and promote health priorities as well. The Breastfeeding Friendly Employer designation is an example of this effort.

c. Plan for the Coming Year

> Ongoing activites as described above
> Establish statewide breastfeeding coalition
> Continue to implement applicable recommendations of the Legislative Report on Breastfeeding (2001)
> Continue to encourage, support and sustain local breastfeeding coalitions.
> Continue to reinforce prenatal breastfeeding promotion and counseling before issuing or increasing amounts of supplemental formula.
> Implement activities for each of the four goals established through the "Using Loving Support to Build Breastfeeding Friendly Community" grant.
> Continue to maintain contracts with local rental stations to provide hospital grade electric breast pumps to WIC participants returning to work and school.

> Work to coordinate training opportunities with the Vermont Lactation Consultants Association (VLCA), Home Health Agencies, Parent-Child Centers, the Healthy Babies, Kids & Families Program and medical care providers.
>Develop a small peer counseling demonstration project in one or more district offices.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	4.5	25	50	85	95
Annual Indicator	22.1	41.2	82.9	94.8	95.7
Numerator	1374	2532	5062	5619	5816
Denominator	6209	6149	6107	5928	6077
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	97	97	98	98	98

Notes - 2002

Starting in June, 2003, the VT CSHN program now receives individual reports of hospital hearing screening, rather than aggregate reports, from each VT birth hospital. Nearly 200 VT babies (3%) are born at home, and an irreduceable number are also transfered to out of state NICU's before screening, so that the ultimate, practical goal (of pre-discharge screening) cannot reach 100%.

Notes - 2003

All VT birthing hospitals began submitting individual reports on babies' hearing screens mid-2003. We are presenting data on 12 months reports, 6-1-03 through 5-31-04. The database is populated by initial heelstick screen reports, so there is not a perfect match with provisional birth certificate data. In addition, two hospitals began reporting 7-1-03, so their contribution to the denominator (and numerator) is only 11 months (all have been screening throughout the year, however). Since the PM asks "before hospital discharge", no homebirths (135) are included.

Notes - 2004

This is our first full year of hospitals' reporting individual babies' results. The denominator of 6077 represents the number of babies who were born in VT hospitals (and, therefore, those who could be screened before discharge). It does not include homebirths, which is a little under 200 per year. Some homebirthed infants are screened as outpatients, and some even by one month of age.In addition, the parents of 11 hospital-born babies refused the screening. Happily, of the 136 babies discharged without a screen, at least 79 were screened as outpatients before 1 month of age (96.6% by 1 month). Our greatest concern is the apparently 128 babies (or

older) for whom heelsticks were reported, but no hearing screening report was received.

a. Last Year's Accomplishments

> all Vermont birth hospitals have implemented Universal Newborn Hearing Screening before discharge
All VT birth hospitals are reporting individual screening results to CSHN to assure tracking and follow-up, so that no infant is missed.

> Grant supported CSHN provides support to hospitals in clinical technique and data gathering (CDC cooperative agreement and MCHB grant)

>Database improvements have been made
> Follow up of each baby born in VT who does not pass, who misses, or who has a risk factor, is available by a pediatric audiologist with CSHN.

Efforts are being made to improve over-the-border follow-up in New England and NY.

We submitted our first aggregate reports using entirely electronic reporting data.

Data for 2004: 95.7% of hospital-born babies screened before discharge; 96.6% screened by one month of age. At least 42% of hospital misses were screened by one month. 0.18% refused screening. Greatest concern: We have no information about hearing screening on 2.1% of babies for whom we do have heelstick results. This is a mixed population of true misses, false misses (screened, but not reported), transfers, wrong names, and other.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Reduce number of missing hospital screening reports			X	X
2. Improve reported data quality and completeness			X	X
3. Implement new CDC-EHDI cooperative agreement			X	X
4. Continue to support all VT birth hospitals to participate in UNHS and to report individual screening results to CSHN to assure tracking and follow-up, so that no infant is missed.			X	X
5. Make needed improvements to accessibility of metabolic/hearing database			X	X
6. Continue to utilize HOP as outpatient re-screening and clinical audiologic follow-up method			X	X
7. > Promote improved and consistent screening and appropriate follow up for infants with risk factors.			X	X
8. > Continue to organize and provide continuing education opportunities for audiologists and early interventionists.			X	X
9. > Continue to work with parent colleagues to create and disseminate information for families and providers.			X	X
10. Calculate and propose to VT legislature an increase in the per-baby newborn screening fee, to include costs of UNHS assurance and follow-up.			X	X

b. Current Activities

Current Activities:

As above; continuing

c. Plan for the Coming Year

Reduce number of missing hospital screening reports

Improve reported data quality and completeness

Implement new CDC-EHDI cooperative agreement

Continue to support all VT birth hospitals to participate in UNHS and to report individual screening results to CSHN to assure tracking and follow-up, so that no infant is missed.

Make needed improvements to accessibility of metabolic/hearing database

Continue to utilize HOP as outpatient re-screening and clinical audiologic follow-up method

> Promote improved and consistent screening and appropriate follow up for infants with risk factors.

> Continue to organize and provide continuing education opportunities for audiologists and early interventionists.

> Continue to work with parent colleagues to create and disseminate information for families and providers.

Calculate and propose to VT legislature an increase in the per-baby newborn screening fee, to include costs of UNHS assurance and follow-up.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	3	3	3	3	3
Annual Indicator	4.2	3.9	4.7	5.5	
Numerator	6190	5420	6550	8060	
Denominator	147523	139560	139560	146630	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**

Annual Performance Objective	3	2	2	2	2

Notes - 2002

Age used is 0-18 vs 0-17 as directed by Title V. Data is pooled March 2001 and 2002 Current Population Surveys. Source is Kaiser Commission on Medicaid and the Uninsured, located at http://statehealthfacts.org.

Notes - 2003

Age used is 0-18 instead of 0-17 as directed by Title V. Data is pooled March 2001 and 2002 Current Population Surveys. Source is Kaiser Commission on Medicaid and the Uninsured, located at http:/statehealthfacts.org

Notes - 2004

The data to calculate this measure for 2004 are currently not consistently available, but will be available at the end of the 2005 calendar year.

a. Last Year's Accomplishments

> Distributed Medicaid eligibility flyers to all school aged children with a postage paid return for information request card

> Monitored by town and AHS region the number and location of returned cards requesting an application for Medicaid. Tested as a follow up contact process with those famlies who were sent an application but did not apply.

> Continued efforts in working with schools to make health insurance status a component of the school emergency card, thus data can be submitted once per year to the VT Department of Education

> Screen all WIC applicants for health insurance status, provide assistance in completing joint application to expedite enrollment in Medicaid/Dr. Dynasaur if interested. All pregnant women, infants and children who meet WIC income guidelines are income eligible for Medicaid.

>Reached a goal of 50% of Vermont schools reporting data on health insurance status to the Vt Dept of Education.

> Screen all WIC applicants for health insurance status, provide assistance in completing joint application to expedite enrollment in Medicaid/Dr. Dynasaur if interested. All pregnant women, infants and children who meet WIC income guidelines are income eligible for Medicaid.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. COntinue long standing EPSDT functions of infomring and outreach	X			
2. COntinue improving Medicaid data analysis to further understanding of access/utilization			X	X
3. Continue WIC screening of clients and provision of information and referral via joint application	X	X		
4. Follow up with families who decline Medicaid	X			
5. Continue data gathering on health insurance status from school health				

records (health emergency card, etc.)				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Current Activities:
> Distributed Medicaid eligibility flyers to all school aged children with a postage paid return for information request card.

> Monitored by town and AHS region the number and location of returned cards requesting an application for Medicaid.

> Continued efforts in working with schools to make health insurance status a component of the school emergency card, thus data can be submitted once per year to the VT Department of Education.

> Screen all WIC applicants for health insurance status, provide assistance in completing joint application to expedite enrollment in Medicaid/Dr. Dynasaur if interested. All pregnant women, infants and children who meet WIC income guidelines are income eligible for Medicaid.

c. Plan for the Coming Year

Plan for the Coming Year:
> Distribute Medicaid eligibility flyers to all school aged children with a postage paid return for information request card

> Monitor by town and AHS region the number and location of returned cards requesting an application for Medicaid.

> Continued efforts in working with schools to make health insurance status a component of the school emergency card, thus data can be submitted once per year to the VT Department of Education

> Screen all WIC applicants for health insurance status, provide assistance in completing joint application to expedite enrollment in Medicaid/Dr. Dynasaur if interested. All pregnant women, infants and children who meet WIC income guidelines are income eligible for Medicaid.

> Continue statewide mechanism to follow up with families who were sent a Medicaid application, but who did not apply. The follow up will attempt to both identify possible barriers to applying and assist families in actually applying. Review lessons learned from prior year activities and identifynew strategies (depending on funding for this activity)

> Continue 50% of Vermont schools reporting data on health insurance status to the Dept of Education.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	87	90	97	97	97
Annual Indicator	94.9	96.8	96.5	81.9	
Numerator	65587	68286	69232	57448	
Denominator	69076	70555	71771	70104	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	95	95	96	97	97

Notes - 2002

The data to calculate this measure for 2002 are currently not consistently available, but will be available at the end of the 2003 calendar year.

Notes - 2003

A segment of the denominator, 8,060 of 70,104, were <19 year olds that were uninsured. All others included in this measure were <21 years old.

Notes - 2004

The data to calculate this measure for 2004 are currently not consistently available, but will be available at the end of the 2005 calendar year.

a. Last Year's Accomplishments

> Work to improve the elements contained in the HCFA 416 report and break that data down by school supervisory union. Work with schools to increase percentage that report this information.

> Continue to improve the percent of schools that report well child visit information to the Dept of Education.

> VDH has provided federally-mandated outreach and informing services to Medicaid families regarding the need for well-child care

> VDH works closely with providers of pediatric care to improve standards, diseminate best-practice information and clarify coding and billing procedures for well-child care to Medicaid-eligible children.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			

	DHC	ES	PBS	IB
1. EPSDT informing and outreach	X	X		
2. Continue focus groups and other activities to create new age-specific informing letters.	X	X		
3. Continue data gathering via via collaboration with schools and school health records.		X		X
4. WIC assessments of insurance status and appropriate referral	X	X		
5. Continue improvements in Medicaid data analysis for better understanding of access and utilization				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

> Continue work on improving the data elements contained in the CMS 416 report and to break down the data set into useful and manageable information.

> Continue to improve the percent of schools that ask a medical home question on the school emergency card as reported to the Vt Dept of Education.

> Improve the image of the correspondence of the VDH federally-mandated outreach and informing services to Medicaid families regarding the need for well-child care.

> Continue to work closely with providers of pediatric care (and PATH, AAP, AAFP) to improve standards, diseminate best-practice information and clarify coding and billing procedures for well-child care to Medicaid-eligible children.

> Continue medical home collaboration with VCHIP for providing TA to providers about medical home services and reimbursement.

c. Plan for the Coming Year

> Work to improve the elements contained in the HCFA 416 report and break that data down by school supervisory union

> Continue to improve the percent of schools that ask a medical home question on the school emergency card as reported to the Vt Dept of Education.

> Improve the image of the correspondence of the VDH federally-mandated outreach and informing services to Medicaid families regarding the need for well-child care.

> Continue to work closely with providers of pediatric care (and PATH, AAP, AAFP) to improve standards, diseminate best-practice information and clarify coding and billing procedures for well-child care to Medicaid-eligible children.

> Continue medical home collaboration with VCHIP for providing TA to providers about medical home services and reimbursement.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	0.6	0.6	1	1	1
Annual Indicator	1.1	1.1	1.0	1.1	
Numerator	72	70	66	75	
Denominator	6487	6349	6371	6581	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	0.9	0.9	0.9	0.9	0.9

Notes - 2002

The data to calculate this measure for 2002 are currently not consistently available, but will be available at the end of the 2003 calendar year.

Notes - 2003

The data to calculate this measure for 2003 are currently not consistently available, but will be available at the end of the 2004 calendar year. Note - final data added for FY 06 application.

Notes - 2004

The data to calculate this measure for 2004 are currently not consistently available, but will be available at the end of the 2005 calendar year.

a. Last Year's Accomplishments

> WIC: Screen all pregnant women for risk factors contributing to pre-term labor and low birthweight, refer to appropriate medical care follow-up. Recall women with specific risk factors for additional education and follow-up (pre-pregnancy underweight, poor weight gain and smoking).

> WIC and HBKF: Assess all pregnant women who smoke for readiness to quit, make cessation services and support available.

> WIC: On-going prenatal assessment for risk factors know to be determinants for pre-term and low birth weight; at-risk women referred to HBKF for home visits beyond WIC program support

> Education for prenatal providers, pregnant women and their partners about management and behavior changes that moderate risks, e.g., identify and have a plan for follow-up for pre-term labor, smoking cessation, adequate prenatal weight gain, multiple births.

> Case management across a system of care to ensure the appropriate community resources

and support are available to at risk pregnant women

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue surveillance and analysis by statisticians and planners				X
2. WIC screening and referral of high risk pregnant women, esp with certain risk factors of smoking, over/under weight, etc.	X	X		
3. Continue Quit Line resources for pregnant women	X			
4. Develop prevention and medical care systems to enhance preconceptual health				X
5. Continue education of health care providers via Regional Perinatal Program		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

> The Department of Health continues to investigate the factors contributing to the low birth weight rate in Vermont, and to look at methods for addressing these factors.
Based on our findings that women with risks that included more than one of three critical factors (pre-pregnancy weight status, weight gain in pregnancy and smoking) had much higher low birthweight rates, we modified our monthly mailing of participants needing specific follow up. Women with two or more of the risks are highlighted, and district staff receive a reminder with the list that these women are very likely to have poor outcomes. Our current recommendations for follow up include:
> Identifying women who are at risk to deliver low birthweight infants as early in pregnancy as possible
> Referring all high risk women for nutrition follow up, medical interventions and home visiting programs as appropriate
> Providing women with an appropriate weight gain goal, based on pre-pregnancy weight status and adjusted for multi-fetal gestation if necessary
> Monitoring women who present with poor weight gain throughout pregnancy, and providing counseling and referrals as needed to help women gain an appropriate amount
> Encouraging all pregnant women who smoke to quit and refer to appropriate community resources for support. Women who cannot or do not want to quit are encouraged to cut down the number of cigarettes to the minimum possible. More tobacco related activities are described in the reports on smoking cessation and environmental tobacco smoke goals.

c. Plan for the Coming Year

> The Department of Health continues to investigate the factors contributing to the low birth weight rate in Vermont, and to look at methods for addressing these factors.
Based on our findings that women with risks that included more than one of three critical

factors (pre-pregnancy weight status, weight gain in pregnancy and smoking) had much higher low birthweight rates, we modified our monthly mailing of participants needing specific follow up. Women with two or more of the risks are highlighted, and district staff receive a reminder with the list that these women are very likely to have poor outcomes. Our current recommendations for follow up include:
> Identifying women who are at risk to deliver low birthweight infants as early in pregnancy as possible
> Referring all high risk women for nutrition follow up, medical interventions and home visiting programs as appropriate
> Providing women with an appropriate weight gain goal, based on pre-pregnancy weight status and adjusted for multi-fetal gestation if necessary
> Monitoring women who present with poor weight gain throughout pregnancy, and providing counseling and referrals as needed to help women gain an appropriate amount
> Encouraging all pregnant women who smoke to quit and refer to appropriate community resources for support. Women who cannot or do not want to quit are encouraged to cut down the number of cigarettes to the minimum possible. More tobacco related activities are described in the reports on smoking cessation and environmental tobacco smoke goals.
> For the Title V Strengths and Needs assessment, the Advisory Committee has chosen a state performance measure of monitoring the percentage of pregnant women who smoke. This is related to the Priority Goal of pregnant women and young children will thrive. See discussion in the SNA. To continue to collaborate with the Tobacco Program on activites.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	9	9	8	8	8
Annual Indicator	10.9	2.2	NaN	NaN	
Numerator	5	1	0	0	
Denominator	45770	45327	0	0	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	8	7	7	7	7

Notes - 2002

Following the procedures outlined in Technical Note IX, Guidelines for Calculating Performance Measures using Small Samples, null values are entered here in lieu of a rate. In 2002, 1child aged 15-19 died by suicide in Vermont, a number below the threshold for which rates are to be calculated.

Notes - 2003

Following the procedures outlined in Technical Note IX, Guidelines for Calculating Performance Measures using Small Samples, null values are entered here in lieu of a rate. In 2003, 4 children aged 15-19 died by suicide in Vermont, a number below the threshold for which rates are to be calculated.

Notes - 2004

Data for 2004 is not yet consistently available, therefore we are using 2003 data as a rough approximation of the situation in 2004.

Following the procedures outlined in Technical Note IX, Guidelines for Calculating Performance Measures using Small Samples, null values are entered here in lieu of a rate. In 2003, 4 children aged 15-19 died by suicide in Vermont, a number below the threshold for which rates are to be calculated.

a. Last Year's Accomplishments

> EPSDT staff have actively participated in the VCHIP Adolescent Health Initiative designed to improve the quality of preventive health services to Vermont adolescents. A series of focus groups were conducted with groups of adolescents and families regarding their experiences and perspectives on preventive health care.

> Suicide deaths continued to be monitored by the Child Fatality Review Committee

Current Activities:
> Staff continue to work with VCHIP Adolescent Health Initiative. One of the goals is to assure that adolescents are screened for risk and protective factors during preventive health visits.

> Suicide deaths continued to be monitored by the Child Fatality Review Committee

> Injury Prevention Coordinator supports efforts of community coalition in southern Vermont (Deerfield Valley Suicide Prevention and Education Committee) to establish school and community programs to educate about suicide.

> VDH currently collects and monitors data on suicide attempts and completions.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Finalize state suicide prevention plan and implement strategies for reducing teen suicide			X	
2. VDH/VCHIP tool for screening teens for depression	X			
3. VDH support of southern Vermont suicide prevention coalition		X		
4. Enhance surveillance of suicides and attempts				X
5. Pilot of child death review data collection tool				X
6. Review of suicides by Child Fatality Review Committee				X
7.				

8.				
9.				
10.				

b. Current Activities

Current Activities:
> Staff continue to work with VCHIP Adolescent Health Initiative. One of the goals is to assure that adolescents are screened for risk and protective factors during preventive health visits.

> Suicide deaths continued to be monitored by the Child Fatality Review Committee

> Injury Prevention Coordinator supports efforts of community coalition in southern Vermont (Deerfield Valley Suicide Prevention and Education Committee) to establish school and community programs to educate about suicide.

> VDH currently collects and monitors data on suicide attempts and completions.

> VDH participation in the MCH Center for Child Death Review

c. Plan for the Coming Year

> Injury Prevention Coordinator supports efforts of community coalition in southern Vermont (Deerfield Valley Suicide Prevention and Education Committee) to establish school and community programs to educate about suicide.

> VDH currently collects and monitors data on suicide attempts and completions.

> VDH participation in the MCH Center for Child Death Review

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	92	92	92	95	95
Annual Indicator	88.9	91.4	83.3	76.0	
Numerator	64	64	55	57	
Denominator	72	70	66	75	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance					

Objective	95	95	95	95	95

Notes - 2002

The data to calculate this measure for 2002 are currently not consistently available, but will be available at the end of the 2003 calendar year.

Notes - 2003

The data to calculate this measure for 2003 are currently not consistently available, but will be available at the end of the 2004 calendar year. Note: data updated for the FY2006 application.

Notes - 2004

The data to calculate this measure for 2004 are currently not consistently available, but will be available at the end of the 2005 calendar year.

a. Last Year's Accomplishments

> Assessment of all pregnant women in WIC clinics (and HBKF) for risks of VLBW and education on available resources for prenatal care. Appropriate referral for high risk clinical care.

> Collaboration with the Regional Perinatal Training Program and the March of Dimes to facilitate the training for transport of pregnant women in PTL and the transport of infants born in community hospitals to regional medical centers.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued support of Vt Regional Perinatal Program training and TA to community birth hospitals.		X		
2. Identification and referal of high risk women by VDH programs and coodination with medical systems to ensure appropriate specialty services.	X	X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

> Assessment of all pregnant women in WIC clinics (and HBKF) for risks of VLBW and education on available resources for prenatal care. Appropriate referal for high risk clinical care.

> Collaboration with the Regional Perinatal Training Program and the March of Dimes to facilitate the training for transport of pregnant women in PTL and the transport of infants born in community hospitals to regional medical centers.

> Collaboration with Northern New England Perinatal Quality Improvement Network (NNEPQIN) to work on systems issues that influence high-risk women and perinatal transport.

c. Plan for the Coming Year

> Assessment of all pregnant women in WIC clinics (and HBKF) for risks of VLBW and education on available resources for prenatal care. Appropriate referal for high risk clinical care.

> Collaboration with the Regional Perinatal Training Program and the March of Dimes to facilitate the training for transport of pregnant women in PTL and the transport of infants born in community hospitals to regional medical centers.

> Collaboration with Northern New England Perinatal Quality Improvement Network (NNEPQIN) to work on systems issues that influence high-risk women and perinatal transport.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	90	90	90	90	90
Annual Indicator	88.4	89.5	89.0	90.6	
Numerator	5459	5443	5443	5696	
Denominator	6173	6084	6115	6290	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	92	92	93	94	95

Notes - 2002

The data to calculate this measure for 2002 are currently not consistently available, but will be available at the end of the 2003 calendar year.

Notes - 2003

The data to calculate this measure for 2003 are currently not consistently available, but will be available at the end of the 2004 calendar year. Note -data updated for the FY 2006 application.

Notes - 2004

The data to calculate this measure for 2004 are currently not consistently available, but will be available at the end of the 2005 calendar year.

a. Last Year's Accomplishments

> HBKF program staff manage and facilitate a comprehensive referral system, which puts entry into early and adequate prenatal care as a top priority. Planning and coordination of efforts to transfer HBKF program to Department for Children and Families.

> Follow-up and outreach is done with individuals through Health Department staff (especially WIC staff) and home visitors to ensure first trimester connection with a prenatal care provider

> Contact with providers to facilitate referrals into the HBKF system of care and other services.

> Conducting a thorough review of program objectives with HBKF partners, including first trimester prenatal care.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC/HBKF identification and referral of pregnant women for first trimester care	X	X		
2. VDH collaboration with OB providers to enhance systems of care for pregnant women		X		
3. Monitoring of population and program data describing elements of prenatal care utilization and using this information for planning and programs				X
4. Coordination with HBKF in the Department of Children and Families.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

> HBKF program staff (now under the Department for Children and Families but continue to coordinate with VDH) manage and facilitate a comprehensive referral system, which puts entry into early and adequate prenatal care as a top priority.

> Follow-up and outreach is done with individuals through Health Department staff (especially WIC) to ensure first trimester connection with a prenatal care provider.

> Contact/outreach with providers to facilitate referrals into the HBKF system of care and other services.

> Vermont has met the Healthy People 2010 goal & HBKF objective for entry into prenatal care in the first trimester. The rate in 2003 was 90.6% (goal is 90%). All systmes will continue activites to mainting this goal and to increase the percentage further.

> Collaboration with Northern New Engalnd Perinatal Quality Improvement Network (NNEPQIN) to work on systems influence outreach and access to women early in their first trimester.

c. Plan for the Coming Year

> HBKF program staff (now under the Department for Children and Families but continue to coordinate with VDH) manage and facilitate a comprehensive referral system, which puts entry into early and adequate prenatal care as a top priority.

> Follow-up and outreach is done with individuals through Health Department staff (especially WIC) to ensure first trimester connection with a prenatal care provider.

> Contact/outreach with providers to facilitate referrals into the HBKF system of care and other services.

> Vermont has met the Healthy People 2010 goal & HBKF objective for entry into prenatal care in the first trimester. The rate in 2003 was 90.6% (goal is 90%). All systmes will continue activites to mainting this goal and to increase the percentage further.

> Collaboration with Northern New Engalnd Perinatal Quality Improvement Network (NNEPQIN) to work on systems influence outreach and access to women early in their first trimester.

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *The percent of Medicaid infants from birth through 12 months who receive home visits through the Healthy Babies system of care.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	45	50%	50%	50%	50%
Annual Indicator	44.2	40.8	59.0	50.1	48.6
Numerator	1683	1609	2172	1830	1880
Denominator	3809	3945	3681	3652	3869
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual					

Performance Objective	50%	50	50	50	50

Notes - 2002

Data are available up through FFY 01. Updated data will be provided for the FFY 05 application. The increase in home visiting as noted for this program is thought to be from a more intensive outreach to families. The data will be monitored over the next year to detect trends and to assess need for changing the long term objectives.

Notes - 2003

Data are for FFY as indicated. Data has been updated for all years reflecting a better process for data entry and also for data retrieval.

a. Last Year's Accomplishments

Last Years Accomplishments:
> Ongoing program administration and development. Program oversight includes quality assurance and fiscal management.

> Risk assessments and referrals are made from any provider in the system of care to the local Health Department MCH Coordinators. Referrals sources include primary care settings, hospitals, WIC, home health agencies, Parent Child Centers, schools, etc. Home visits and care coordination are offered as a benefit of the program, particularly for high risk clients.

> The percent of eligible clients accepting home visits (~50%) has remained the same. However, the percent of clients who are at higher risk and require a more intensive level of services has increased. Also, there has been a greater shift to the provision of more nursing than family outreach & support visits, resulting in demand for more services than the program budget can support. A case management and prior authorization of home visit process has been implemented to assure appropriate services, based on risk criteria and program objectives as well as management of the program budget.

> Vermont is embarking on a re-organization of the Agency of Human Services and the development of a unified system of early care, health and education for families with young children. A new Department of Children & Families will house the Division of Child Development, which will include the HBKF program (which currently sits in the Dept. of Health). A transition period in which to make these changes will begin July 1, 2004.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue collaboation with WIC and HBKF and other service coordination activities in VDH and DCF to allow families to recieve Healthy Babies Services		X		
2.				
3.				
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities

Plan for the Coming Year:
> Continued transition of the HBKF program to the new Department of Children & Families, Division of Child Development. The goal is to improve service coordination for families through co-location of providers, increased provider collaboration, blending of funding streams and increased flexibility about use of resources for families.

c. Plan for the Coming Year

Plan for the Coming Year:
> Continued transition of the HBKF program to the new Department of Children & Families, Division of Child Development. The goal is to improve service coordination for families through co-location of providers, increased provider collaboration, blending of funding streams and increased flexibility about use of resources for families.

> This measure will not be continued in to the next five year cycle, although the HBKF program activities will be continuing in its new home in DCF. Close collaboration between the VDH and HBKF will continue, especially under the new goals of promoting medical and dental homes and supporting women and children to thrive. Opportunities to support women and children will continue either via home visit or other community based services.

> An integrated model for delivery of family services that combines HBKF, Family/Infant/Toddler, CUPS, Success by Six and Head Start,will be developed and impelmented for FY07.

State Performance Measure 2: *The percent of low income children (with Medicaid) that utilize dental services in a year.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	50%	50%	50%	51%	51
Annual Indicator	46.1	45.6	46.6	48.0	47.7
Numerator	32684	32945	34560	35733	35845
Denominator	70944	72208	74129	74501	75144
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual					

Performance Objective	52	52	54	54	55

Notes - 2002

For Fiscal Year, 10/1/01 to 9/30/02.

Notes - 2003

For FFY 2003

Notes - 2004

The measure of low income children's utilization of dental services will be continued as a state performance measure for the next Title V five year block grant cycle. Related to Priority Goal of "All children will receive continuous and comprehensive oral health care within a dental home."

a. Last Year's Accomplishments

Last Years Accomplishments:
> Continue to administer and expand Tooth Tutor programs as capacity allows. Expansion possible via RWJ grant.

> Continue to monitor, via the school health emergency card, the number of children reporting they do not have a dental home.

> Continue with development of oral health state plan to be written in conjuction with the State Oral Health Advisory Committee.

> Begin qualitative data gathering to guide the development of the oral health public media campaign.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue with activities to expand tooth tutor program	X	X		
2. Enhanced outreach with RWJ grrant activities	X	X		
3. RWJ outreach strategies to support access to dental home			X	X
4. Enhanced dental surveillance with Medicaid data and other newly available sources of data (such as hospital discharge and ED use)				X
5. Continue with public media campaign encouraging preventaive dental hygiene practices		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Current Activities:
> Continue to adminster and expand Tooth Tutor program as capacity allows.

> Continue to monitor, via the school health emergency card, the number of children reporting they do not have a dental home.

> Continue with development of oral health state plan and implement recommendations appropriate for this measure, ie; those that address outreach and dental home for children who use Medicaid.

> Continue management of the Oral Health public media campaign advising Vermonters, especially those of low income, to obtain preventive oral health services.

c. Plan for the Coming Year

> Continue with development of oral health state plan and implement recommendations appropriate for this measure, ie; those that address outreach and dental home for children who use Medicaid.

> Continue to adminster and expand Tooth Tutor program as capacity allows.

> This performance measure will be continued into the next five year cycle as a means of measuring progress toward the goal of all children receiving care within a dental home.

State Performance Measure 3: *The percentage of Vermont Department of Health districts that have a community-based hearing screening and diagnostic follow-up program (Hearing Outreach Program) for children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	100%	100%	100%	100%	100%
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	12	12	12	12	12
Denominator	12	12	12	12	12
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100%	100	100	100	100

Notes - 2002

HOP is evolving in two important directions, both of which argue for continuing to monitor as a SPM: increased role as next-steps follow-up for UNHS; and, transition from grant funding to reimbursement funding.

Notes - 2003

The objective of 100% has been achieved. This PM will be reconsidered in the FFY06 application, using information from the MCH needs asessment and hearing program information. See also endnote for NPM12. These PM's are important to monitor as the UNHS

program continues to expand and refine capacity for screening, data collection, and fee reimbursement.

Notes - 2004

The objective of 100% of communities offering hearing screening programs has been achieved for the past several years. The monitoring for comprehensive, universal hearing screening services will be continued via NPM #12.

a. Last Year's Accomplishments

> We continue to have Hearing Outreach Program sites in the 12 regions. We have increased the numbers of clinics and numbers of children seen, by increasing pediatric audiology staff time.

> HOP has, as hoped, become the follow-up method of choice for infants needing follow-up to UNHS.

> providing on-site screening at Head Start programs has proved unworkable; all HS parents are welcome to refer their children to the local HOP clinics for screening, as needed.

> Third party billing has implemented; one major private insurer, however, has refused to cover "screening" without a physician present.

> A protocol for infant audiologic diagnosis has been completed, reviewed by stakeholders, and disseminated.

> Our HOP audiology director resigned; we have successfully filled her position, but have created another vacancy in so doing.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. > Continuing focus on capacity adjustment for the increasing referrals to HOP.			X	X
2. > Focus on increasing third party reimbursements.			X	X
3. Recruiting for new audiologist for the southern part of the state and exploring contracting with local audiologists.			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

> As above, and...

> Continuing focus on capacity adjustment for the increasing referrals to HOP.

> Focus on increasing third party reimbursements.

> Recruiting for new audiologist for the southern part of the state and exploring contracting with local audiologists.

c. Plan for the Coming Year

> Continue to stabilize the system for third party reimbursements.

> Continue work with an information systems contractor to improve the linkage between the UNHS database and the HOP clinical activities so that follow-up occurring in HOP is automatically linked to the UNHS record, thus closing the loop.

> Pilot contracting with local pediatric audiologists for HOP, to improve community connections and to reduce travel costs.

> These activities will continue via Title V and the VDH CSHN program, although this measure will not be included as a Title V SPM.

State Performance Measure 4: *The percent of primary caregivers in the Women, Infants and Children (WIC) program who report placing infants to sleep on their backs as the usual sleeping position.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	80%	81%	82%	87	87
Annual Indicator	73.6	80.2	86.1	87.3	87.8
Numerator	1881	2156	2393	2390	2474
Denominator	2554	2689	2780	2738	2819
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	88	89	90	90	90

Notes - 2002

The denominator for this measure has been revised to capture "infants with known sleeping position" not "total infants enrolled in WIC." The data for 2001 and 2002 reflect the new definiiton of the denominator.

Notes - 2003

Data reflect the WIC population enrolled during December, 2003. The denominator for this measure has been revised to capture "infants with known sleeping position" and not "total infants enrolled in WIC." The data for 2001, 2002, and 2003 reflect this change in definition.

Notes - 2004

The monitoring of caregivers actions in sleep position of infants will be continued via WIC and also other public health data systems such as PRAMS. Education programs for parents, health care providers, and child care providers will continue via many programs such as WIC, EPSDT, and HBKF.

a. Last Year's Accomplishments

Last Years Accomplishments:
> Goal is reduce the risks of infant death from SIDS through caregiver education and influencing parenting practices.

> On-going collection of caregiver information about infants' primary sleep position at the 6 week and 6 month WIC certification. This information is reported out from WIC data, and contributes to a more comprehensive analysis and inquiry of SIDS sleep position and sleep environment factors. This, in turn, informed targeted statewide interventions to reduce infant deaths.

> National and state SIDS/Back to Sleep brochures and parent educational materials are available to caregivers through WIC clinics, primary care practices, hospitals, home visiting programs, parenting classes, private insurance informational packets. These materials are used to augment provider education and recommendations around safe infant sleep position and other protective factors, e.g., no smoking, breastfeeding.

> Coordinate with VDH Medical Examiner and Child Fatality Review Committee on collecting Vermont-data describing incidents of SIDS where there were identified risks of unsafe sleep environment.

> Begin review of national brochures advising parents of safe sleep environments

> Review research about risks of sleeping in adult beds and overall safe sleep environment to be reviewed and a Vermont-specific brochure to be developed.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue education and reporting activities via WIC	X	X		
2. Continue education activities via other programs such as HBKF, hospital nurseries, child care providers	X	X		
3.				
4.				
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities

> On-going collection of caregiver information about infants' primary sleep position at the 6 week and 6 month WIC certification. This information is reported out from WIC data, and contributes to a more comprehensive analysis and inquiry of SIDS sleep position and sleep environment factors. This, in turn, informed targeted statewide interventions to reduce infant deaths.

> National and state SIDS/Back to Sleep brochures and parent educational materials are available to caregivers through WIC clinics, primary care practices, hospitals, home visiting programs, parenting classes, private insurance informational packets. These materials are used to augment provider education and recommendations around safe infant sleep position and other protective factors, e.g., no smoking, breastfeeding.

> A brochure describing a safe sleep environment for infants targeting parents and care givers is being prepared.

> An evaluation and revision of the current Vermont SIDS program is underway.

c. Plan for the Coming Year

> On-going collection of caregiver information about infants' primary sleep position at the 6 week and 6 month WIC certification. This information is reported out from WIC data, and contributes to a more comprehensive analysis and inquiry of SIDS sleep position and sleep environment factors. This, in turn, informed targeted statewide interventions to reduce infant deaths.

> National and state SIDS/Back to Sleep brochures and parent educational materials are available to caregivers through WIC clinics, primary care practices, hospitals, home visiting programs, parenting classes, private insurance informational packets. These materials are used to augment provider education and recommendations around safe infant sleep position and other protective factors, e.g., no smoking, breastfeeding.

> Distribute safe-sleep environment brochure

> Continue to revise the SIDS/SUDI program to reflect latest research and best practices.

> This measure will not be continued into the next five year Title V cycle, however, the program activities via the VDH and partners such as the Child Fatality Review Committee and the Chief Medical Examiner will be continued.

State Performance Measure 5: *The percent of youth aged 12-17 who use alcohol.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004

Annual Performance Objective		41%		40	
Annual Indicator		43.1		39.0	
Numerator		16709		15180	
Denominator		38777		38967	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	39		38		

Notes - 2002

There is no updated survey data for 2002. The YRBS will be conducted again in the Fall of 2003.

Notes - 2003

Data is from the 2003 Vermont YRBS which was conducted Fall, 2003.

Notes - 2004

There is no updated survey data for 2004. The YRBS will be conducted again in the fall of 2005. This measure will be retired in FFY06, however, monitoring of this data will continue via Title-V and related programs within VDH.

a. Last Year's Accomplishments

Last Years Accomplishments:
> EPSDT staff have worked closely with Vermont Child Health Improvement Project (VCHIP, an organization designed to work with physicians to improve the quality of preventive health services to adolescents. Collaboration to set guidelines for well-adolescent visits for screening for risks/assets to determine potential for alcohol use and abuse. Use of CRAFFT.

> Associated work on prenatal alcohol use via the WIC/Rocking Horse collaboration.

> Collaboration with Office of Drug and Alcohol Abuse programs and community based New Directions programs.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue intervention and prevention activities via Mental Health, Office of Drug and Alcohol, school-based programs, etc.	**X**	**X**		
2.				
3.				
4.				
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities

Current Activities:
> EPSDT staff continue to work closely with Vermont Child Health Improvement Project (VCHIP, an organization designed to work with physicians to improve the quality of preventive health services to adolescents. Collaboration to set guidelines for well-adolescent visits for screening for risks/assets to determine potential for alcohol use and abuse. Use of CRAFFT.

> Associated work on prenatal alcohol use via the WIC/Rocking Horse collaboration.

> Collaboration with ODAP and community based New Directions programs.

c. Plan for the Coming Year

> EPSDT staff continue to work with the Vermont Child Health Improvement Project (VCHIP, an organization designed to work with physicians to improve the quality of preventive health services to adolescents. Collaboration to set guidelines for well-adolescent visits for screening for risks/assets to determine potential for alcohol use and abuse. Use of CRAFFT.

> Associated work on prenatal alcohol use via the WIC/Rocking Horse collaboration.

> Seek opportunities for collaboration with Mental Health Programs, as a result of the AHS reorganization and the combining of Department of Mental Health with the Department of Health.

> Collaboration with ODAP and community based New Directions programs.

> Although this performance measure will not be continued into the next Title V five-year cycle, the activities will continue and will be relevant to the new Title V goal of supporting youth to choose healthy behaviors.

State Performance Measure 6: *The percent of 8th grade youth who smoke cigarettes.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		19%		14%	
Annual Indicator		12.7		11.1	
Numerator		992		886	
Denominator		7823		7959	

Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	12		10		

Notes - 2002

There is no updated survey data for 2002. The YRBS will be conducted again in the Fall of 2003.

Notes - 2003

Data is from the Vermont YRBS which was conducted Fall 2003

Notes - 2004

There is no updated survey data for 2004. The YRBS will be conducted again in the fall of 2005. This measure will be retired n FY06. However, monitoring of this data will continue via Title V and related programs within VDH. A new measure will monitor smoking and pregnant women.

a. Last Year's Accomplishments

Last Years Accomplishments:
> Continue with Vermont Kids Against Tobacco (VKAT.) Peer leadership program provides training, TA, and funding for middle school aged youth to educate peers and younger children about tobacco, marketing, and to promote a tobacco free lifestyle. There are approximately 60 VKAT sites. Over 400 youth participated in the annual state house rally, where they marched in the state capital and spoke with legislators.

> Our Voices Exposed (OVX) is the peer leadership program for high school aged youth. Emphasis on peer leadership, community organizing, media literacy, and research based prevention activities. There are nearly 30 OVX sites.

> Youth from 24 OVX sites attended training to learn about tobacco industry marketing tactics and ways to influence their peers. Also attended one-day summit with other youth to further learn about the dangers of tobacco.

> Developed the "Butts of Hollywood" campaign to focus on the issue of smoking in the movies - use of three comercials that air around the state on TV and in eleven theaters, letter writing campaigns, educational activites at the movie theaters.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue prevention education and cessation activities via VDH and partners such as schools and community groups.	**X**	**X**		
2.				
3.				
4.				
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities

Current Activities:

> Continue with VKAT activities as described above.

> Continue with OVX activities as described above.

> Continue with "Butts" of Hollywood

c. Plan for the Coming Year

Current Activities:
> Continue with VKAT activities as described above.

> Continue with OVX activities as described above.

> Continue wiht the "Butts" of Hollywood.

> This measure will not be continued in the next five year cycle for Title V, however, the activities will continue and will be related to the new Title V Goal of Youth Choose Healthy Behaviors.

State Performance Measure 7: *The percent of Women, Infants and Children (WIC) program families who use feeding practices that prevent Baby Bottle Tooth Decay (BBTD).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	75%	95%	95%	95%	95%
Annual Indicator	93.3	92.1	92.3	92.4	92.4
Numerator	12003	11582	11996	11945	11945
Denominator	12866	12571	12993	12933	12933
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**

Annual Performance Objective	95%	95	95	95	95

Notes - 2003

Data reflect the WIC population enrolled on July, 2003

Notes - 2004

This measure will be retired in FFY06, but monitoing of this data will continue via WIC and VDH Dental Services.

a. Last Year's Accomplishments

> In July of 2002, a query of risk factors assigned to currently active infants and children showed that 92 percent had feeding practices that prevent baby bottle tooth decay, leaving only 8 percent who take a bottle to bed, walk around all day with a comfort bottle or routinely drink liquids other than breastmilk, milk or formula from a bottle.
> WIC: Ongoing provision of sippy cups to each WIC-active infant at the six month re-certification visit, and a new toothbrush for the one year visit. Use of a targeted nutrition education message as items are given to families.
> WIC: Ongoing education of all parents about the need for water testing to determine whether or not fluoride supplements are needed. Offer information about the causes of early childhood dental caries, ways to prevent caries, and early signs of dental decay.
> To facilitate referrals and follow-up for dental problems, WIC uses a pediatric referral form to communicate issues that either need immediate follow-up and an expedited dental appointment (such as active decay or white spot lesions), or that need to be discussed at the next pediatric well-child visit (such as maternal tooth decay, older siblings with early childhood decay, bedtime bottle feedings or the need for fluoride supplements).
> WIC: BBTD initiative includes agreements with dentists who will give priority appointments, with little or no waiting time and without regard to source of payment, to young children who have been referred by their pediatrician.
> Close coordination with VDH Dental Health Unit to improve educational materials for both parents and dentist.
> WIC distributes a dental health newsletter to pediatric and general dentists.
> WIC: Coordinate parent education and family referral systems with child care providers.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue education of caregivers via WIC, childcare facilities, and health care providers.	X	X		
2.				
3.				
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities

Current Activities:
> Continuation with actions listed for previous year.
> WIC continues to provide sippy cups to each WIC-active infant at the six month re-certification visit, and a new toothbrush for the one year visit with a targeted nutrition education message for each item. As an alternative to sippy cups, we would like to provide a small cup with a tight-fitting lid but no spout. Thus far, we have been unable to locate an appropriate cup but we continue to explore options.
> Continue close coordination with VDH Dental Unit.
> As part of our current special project grant WIC Services in the Medical Home: Improving Early Feeding Practices, three control districts and three provider practices are collecting detailed information on feeding practices. While the purpose of the data collection is to determine whether the WIC-MD model is effective in changing feeding practices, the information gathered in the control offices will also help us identify the most commonly used practices that are not evidence-based. We can use this information focus nutrition

c. Plan for the Coming Year

Current Activities:
> Continuation with actions listed for previous year.
> WIC continues to provide sippy cups to each WIC-active infant at the six month re-certification visit, and a new toothbrush for the one year visit with a targeted nutrition education message for each item. As an alternative to sippy cups, we would like to provide a small cup with a tight-fitting lid but no spout. Thus far, we have been unable to locate an appropriate cup but we continue to explore options.
> Continue close coordination with VDH Dental Unit and engage in planning with the new Dental Director and also to implement activities decided fromthe State Oral Health Plan.
> Although this performance measure will not be continued into the next Title V five-year cycle, these activities will continue and will be relevant for the new goal of increasing the number of children served via a dental home.

State Performance Measure 9: *An annual assessment of the quality of the CSHN data system by the CSHN medical and administrative management, using a scoring system developed specifically for this purpose. (See definition.)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	9	9	3	3	5
Annual Indicator	3	3	3	4	5
Numerator					

Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5	6	7	7	

Notes - 2002

Now with several years' experience in this SPM, we have revised the definition and scoring system. The PM now focuses on the accessibility, quality, and integration of the CSHN database; at the initiation of this measure, there were many CSHN staff who did not even have computer access. The database was completed in 2002 and staff were trained. The scoring revisions now place more emphasis on data quality; therefore, the scores are LOWER than last year, and the projections are revised. For 2002:
Staff access: 1 of 2
Completeness: 1 of 2
Accuracy: 1 of 2
Integration with Medicaid: 0 of 2
Integration with Part C: 0 of 2
Integration with Accounts Payable: 0 of 2

Notes - 2003

The PM focuses on the accessibility, quality, and integration of the CSHN databases. As a sign of success, at the initiation of this measure, there were many CSHN staff who did not even have computer access - now all staff have ready access to a computer. The database was completed in 2002 and staff were trained in its use. The scoring revisions (first used in FY2004 application) place more emphasis on data quality, therefore scores are lower and the projections revised. This SPM is scored 0-2 on each of 6 constructs: staff access, completeness, accuracy, integration with Medicaid, integration with Part C, integration with accounts payable, with a maximum score of 12. This year staff access = 2; completeness and accuracy each = 1. In past years, we had entered the score as the numerator with a denominator (maximum score) of 12. However, the web form translated these into indicators of zero. Therefore, this year, we have removed all numerator/denominator components and just entered the total score as the indicator.

Notes - 2004

0=none 1=partial 2=complete achievement.
In 2004:
Staff access=2
Completeness of data=2
Accuracy=1
Integration with Medicaid=0
Integration with Part C=0
Integration with Accounts Payable=0
Within our CSHN unit we have expanded the fields of data. While we are able to capture information about whether children have Medicaid or are enrolled in Part C, there is no integration or linkage of these databases. This measure will be retired in FFY06, however, the activities to improve CSHN data systems will continue.

a. Last Year's Accomplishments

> The CSHN Cost-share database continues to be stabilized and made accessible to all staff.

Encounter and diagnostic data continues to be entered into a 1031

format, which is accessible only to a very few IS staff at the department level.

Parent to Parent of VT provided CSHN valuable data about parent needs from their own database (which CSHN helped to fund).

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to focus on improvement of data quality, access and utilization by program staff for clinical and planning purposes.				X
2. Make progress with linkage to Accounts Payable data				X
3. Make progress with linkage to Encounter data				X
4. Make progress with linkage to Medicaid eligibility (and loss of eligibility) data				X
5. Continue to analyze and apply Parent to Parent data.				X
6. Begin to utilize similar data from VT Parent Information Center.				X
7.				
8.				
9.				
10.				

b. Current Activities

As above.

> The reorganization of the Agency of Human Services includes a plan to centralize the Information Systems supports across departments. We are uncertain at this point what the impact of IS centralization will be on CSHN programs' ability to improve its patient care and program data.

c. Plan for the Coming Year

Continue to focus on improvement of data quality, access and utilization by program staff for clinical and planning purposes.

Make progress with linkage to Accounts Payable data

Make progress with linkage to Encounter data

Make progress with linkage to Medicaid eligibility (and loss of eligibility) data

Continue to analyze and apply Parent to Parent data.

Begin to utilize similar data from VT Parent Information Center.

Incorporate these activities into the new goals for the Title V, espcially those supporting CSHCN to be served through a medical home.

State Performance Measure 10: *The percent of youth in grades 8 through 12 who are overweight or obese.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				22	
Annual Indicator		23.2		26.0	
Numerator		1863		9350	
Denominator		8035		35967	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	22		20		

Notes - 2002

This is a new measure for FFY 04 application. Data available from YRBS for 1999 and 2001, the years in which the BMI was calculated from self report by the survey participants. New VDH initiatives are being planned to address this SPM (and also Vermont Priority Need #10) and the resultant effect on the annual indicator will be analyzed. Long term objectives will be adjusted accordingly.

Notes - 2003

This is a new measure for FFY 04 application. Data is from the YRBS for 1999 and 2001, the years in which the BMI was calculated from self report by the survey participants. Data for 2003 is unweighted, for previous years data is weighted. New VDH initiatives are being implemented to address this SPM (see also Priority Need #10)

Notes - 2004

There is no updated survey data for 2004. The YRBS will be conducted again in the Fall of 2005. This measure will be retired in FFY06, however the issue of youth and obesity continues to be addressed by serveral VDH and community programs. A new measure for the next five year Title V cycle will allow monitoring of obesity in women of childbearing age.

a. Last Year's Accomplishments

> This measure was added for FFY 05 in response to the increase in overwieght and obse children in Vermont and nationally. In addition, the Title V Priority Need #10 is Reduce childhood overweight and obesity.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Continue planning and coordination of action steps using CDC obesity				

grant funds - such as Run Girl Run, school programs, survey of exercise opportunities in each community, etc.	X	X		
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

> Nutrition and weight counseling in WIC clinics

> Fit and Healthy Kids for WIC children and also has been expanded for certain non-WIC children.

> VDH Run Girls Run - for encouraging middle school girls to be comfortable with exercise and also build self esteen - expands the number of sites

> Development of a comprehensive school wellness policy for nutrition and physical activity in schools. TA from VDH and DOE will be available to particpating schools.

> Development of state plan for obesity prevention - funded by CDC grant - to be completed by October, 2005.

> Completion of a statewide inventory of existing programs for obesity prevention.

c. Plan for the Coming Year

> This measure will not be continued into the next five year Title V cycle. However, the activities will continue and will be related to the Title V goal of Youth Choose Healthy Behaviors. Please see also the discussion about overweight women and children in the Strengths and Needs Assessment.

E. OTHER PROGRAM ACTIVITIES

MCH Toll Free Line: Vermont's toll-free, confidential telephone MCH information and referral service is called "Help Your Baby, Help Yourself," nicknamed the HelpLine (see Form 9 and endnote). Funding for this program was eliminated in the state budget and the hotline ceased operation via the Agency for Human Services in November, 2002. The Pregnancy Hotline Calls and response services are now managed by VDH/Division of Community Public Health which provides coverage for the entire state. Callers are referred to the appropriate VDH district office and assisted by a public health nurse or nutritionist. Ongoing statewide PAL calls are answered by United Way who receives funding from a variety of sources, including AHS. In 2005, the United Way is beginning to offer a statewide comprehensive response service (via 211 system) and is collaborating with various programs in VDH which are interested in a public toll free education/advice system.

Refugee Program: Health evaluation for newly arriving refugee families takes place within 30 days of arrival and is conducted by the Community Health Center in Burlington and private health care providers. VDH recruits and orients primary care providers for assessment, treatment, and ongoing management of refugee health needs. The Refugee Health Coordinator, the State Coordinator, and the District Office staff work closely with the Vermont Refugee Resettlement Program, the Office of Minority Health, and private providers to assure that care is available, accessible, and culturally appropriate. Interpreter services are arranged through contacts with the local resettlement agency, as well as with the LLE (Language Learning Enterprises.) Between 1980 and 2004, Vermont received 4,770 refugees. In 2004, 270 refugees arrived in Vermont. The goals of the refugee health program continue to focus on health education and training for both providers and refugees and infectious and chronic disease case management and services coordination through the provider medical home.

Children's UPstream Service (CUPS) a Services Initiative Grant from the federal Center for Mental Health Services. Key project objectives are: 1) Enhance the ability of Vermont's existing Community Partnerships to improve linkages of services for school aged children with SED with the early childhood system of care, 2) Statewide expansion of key services aimed at strengthening the behavioral health of young families.

State Incentive Cooperative Agreement (New Directions): One of five states funded via the National Youth Substance Abuse Initiative. The goal is to reduce use of alcohol, tobacco, marijuana and other drugs by teens (aged 12-17) through a network of community based activities.

The Office of Rural and Primary Care receives funds from the Bureau of Primary Health Care and the Federal Office of Rural Health Policy to improve access to health services for underserved populations. This is done through planning, technical assistance, grants, coordination and advocacy. An advisory group guides the work of the Office. Activities of the Office include the development and administration of medical and dental loan repayment programs, grants to community organizations for services and/or infrastructure development, training and technical assistance to community based health care organizations, assessment of the need for health services in communities, workforce coverage analysis and trends, and application for Federal designations of underservice. The Steering Committee is composed of a broad range of provider groups concerned with access to care including the Medicaid program, Mental Health Department, Department of Aging, Hospital Association, Medical Society, Primary Care Association, Dental Society and Area Health Education Center. Recent projects are the development of a set of criteria to identify Vermont communities at high medical need in order to seek Governor Designations of underservice and expand the opportunities for participation in the Federally Qualified Health Centers programs and reassessment of the State Loan Repayment Program for primary care providers. A loan repayment system for nurses was enacted by the state legislature in 2002 and now nursing loan repayments and loan forgiveness have been added to the cadre of loan repayment programs. The Primary Care Loan Repayment Program was updated and final policy recommendations were completed in June, 2002. With the closure of the USDA Waiver program, the State Conrad 20 Program has become much more active. Some of the current state activities include: using the new governor's designation criteria to identify areas for the development of RHC's and FQHC's, working with the UVM Office of Nursing, the Nursing Board, regional colleges and universities as well as community hospitals to develop a curriculum and infrastructure to facilitate the reentry of nurses whose licenses have lapsed back into the field. In 2004, the Office began working with the Medicaid Office, Dept of Developmental and Mental Health and the Office of Alcohol and Drug Abuse programs to examine policy, programming and funding to support the integration of behavioral health and primary care. In 2003, the Office received a grant from the RWJ Foundation to increase access to oral health services for Medicaid/SCHIP eligibles. This grant has been used to: develop reimbursement strategies to improve access to dental care, expand school based oral health programs, provide consumer prevention education and enhance oral health provider recruitment and retention. The Office has been very active in the planning of the Vermont State Oral Health Plan.

F. TECHNICAL ASSISTANCE

Description of Technical Assistance Requested:

Vermont has recently gone through a comprehensive reorganization of the Agency of Human Services in order to better serve the citizens of the state through more integrated, effective and efficient service delivery models. Existing programs, which directly benefit families with young children, have come together under the new Child Development Division (CDD) in the Department for Children and Families.

The purpose of the new division is to assure a coordinated, statewide system of child development services that promotes and supports safe, accessible, quality services for Vermont's children and their families. The CDD mission is to improve the well being of Vermont's children. This occurs in partnership with families, communities, schools, providers and state and federal agencies. CDD services are family-centered, family-friendly, high quality, economically viable and accessible.

Within the CDD, an Integrated Services Team is charged with developing a new model of service delivery which will meet these identified goals and objectives. This represents a broad based, multi-disciplinary approach to the delivery of developmental services for families with young children, beginning in pregnancy. Disciplines include mental health, health, early intervention, family support and education and child care.

Research to find an existing model to provide a framework for this planning process has resulted in interest in the UCLA Center for Healthier Children, Families and Communities' Model of Developmental Services In Orange County*. This model "focuses on the dual goals of healthy development and school readiness for all children, with the framework of strong families and an integrated quality service system".

Reason why assistance is needed:

Applying this developmental services model will require significant change from current practice for the range of early childhood providers at both state and local levels. Changes include closer coordination and collaboration among families and providers, closer coordination and collaboration among providers with diverse areas of expertise who work with different programs and state or private agencies; funding flexibility; workforce training and development; and data collection and evaluation.

The Integrated Services Team members would like to make use of the resources and expertise of UCLA staff to assist in addressing the challenges and opportunities inherent in these proposed changes. We are asking for technical assistance in applying the UCLA Model of Developmental Services to Vermont needs, as well as help to engage stakeholders in a variety of ways to ensure the success of implementing a new approach to providing comprehensive, developmental services.

What entity would provide the TA:

Ideally, we would consult with UCLA staff that developed and/or are implementing the model in Orange County. Consultation could be done via phone and email. An on-site visit presentation (e.g., Neil Halfon, MD, MPH) to an audience of stakeholders, would be a powerful way to promote the new model and create some buy-in by providers. Use of already developed technology, such as PowerPoint presentations or training curriculums, would be invaluable.

It may also be possible to coordinate technical assistance contacts with other projects that Vermont and UCLA are involved in, such as at the national MCHB/HRSA meetings in the fall, Region I Learning Collaborative (Title V), and common Region 1 state performance measure for Title V.

V. BUDGET NARRATIVE

A. EXPENDITURES

Expenditure trends. The following factors have had, or are likely to have, an impact on MCH-related expenditures:

• Reorganization. The Agency of Human Services reorganization brought the Mental Health program into the Health Department. The impact of this change on the Department's finances is enormous. Mental Health costs are now over half of the entire Health Department. None of the Mental Health expenditures are included in this report for FY06. "Other federal funds" does not include Mental Health funding, although a large share of these expenditures are for children. On the other hand, several programs that were closely related to Title V have been moved to the new Department for Children and Families, including the payments to community providers for the Healthy Babies program serving pregnant women and infants, and the Family, Infant and Toddler Program funded by the U.S. Dept of Education and formerly part of Vermont's CSHN.

• Medicaid payments for MCH services. Medicaid payments for CSHN clinics have increased remarkably in recent years. This is the largest change in the expenditure pattern related to MCH services, and it leads to a reduction in our charges to Title V. This increase in Medicaid payments is due partly to improved billing procedures, partly to obtaining more favorable reimbursement rates, and partly due to the ability to obtain Medicaid reimbursement for a larger percentage of Medicaid children, especially those with other insurance coverage. This pattern has been noted in the last several years, but the impact became larger in FY 2002 and 2003, and therefore is apparent in our FY2004 expenditure report and in budgets for future years. See attached chart.

Expenditure documentation. Vermont began using its current accounting system in FY'02. The system is named "VISION," which is an acronym for "Vermont Integrated Solution for Information and Organizational Needs". The accounting package includes the Financial and Distribution modules contained within PeopleSoft's software suite for Education and Government (E&G) version 7.5. It is designed to be an integrated financial and management tool. While most transactions are entered into VISION directly, payroll information is currently run on a separate system and summary payroll data are extracted from the Human Resource Management System (HRMS) and uploaded into VISION. The HRMS software is also a PeopleSoft product and is compatible with VISION. Upgrades to both VISION and HRMS will be implemented in tandem. The VISION system was implemented with as few Vermont-specific characteristics as possible so that future upgrades could be accepted with relatively minimal retrofitting work. VISION contains a number of modules that allow for a variety of functions, such as asset management, as well as expenditure tracking.

The Vermont Health Department can provide assurance that we have established "such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement and accounting" [Sec 502(a)(3)].

Cost Allocation. The Vermont Health Department operates under a Cost Allocation Plan approved by the DHHS Division of Cost Allocation. Our Plan is being revised during FY2005 due to the AHS reorganization. This Plan determines how we will collect certain overhead costs into cost pools and how those overhead cost pools will be allocated to the various programs and funding sources, including the Maternal and Child Health Block Grant. Because we have an approved Cost Allocation Plan, Vermont does not have an indirect rate agreement, which would be the alternate method for charging overhead costs to programs. Cost Allocation Plans--instead of indirect rate agreements--are relatively rare among Health Departments. Basically, the approved methods collect general overhead costs on a quarterly basis into cost pools at the division level and also at the Department-wide level. Allowable charges from the Statewide cost pool are also determined. These three overhead cost pools (division, department and statewide) are then allocated to all of the programs in the department (including state funded programs as well as federally funded programs). The allocation process is based on the relative direct salary costs of each program in the quarter.

In addition to the distribution of the three cost pools listed above, for the purposes of reporting our expenditures for the Maternal and Child Health Block Grant, the overhead costs of the Children with Special Health Needs unit are also distributed to the direct programs provided by that division. The distribution of these costs is based on the relative direct salary costs of CSHN staff in each of its programs in the quarter. Although CSHN is not designated as a "division" of the Health Department, it seems to be most equitable to distribute these costs in a manner that mimics the distribution of divisional overhead costs. This results in a fairer picture of the true cost of each of the individual clinics and programs operated by CSHN.

Our revised plan has been submitted to the DHHS Division of Cost Allocation. It is currently under review. The Vermont Agency of Human Services is working with Public Consulting Group, Inc., of Boston in this revision.

Single State Audit. The State Auditor of Accounts arranges for an annual audit in compliance with the Single Audit Act, as well as in conformity with Section 506(a)(1) of the Maternal and Child Health Block Grant. The audit is performed by KPMG under contract with the Auditor of Accounts. Although the Maternal and Child Health Block Grant does not qualify as a "major" program for audit purposes, transactions may be tested as part of a general review of management control. There were no findings related to expenditures funded by the Maternal and Child Health Block Grant in FY 2004.

B. BUDGET

Consolidated Budget. In Vermont, the Department's budget includes both State funds and all if the federal funds available to the Department. Because it is a consolidated budget--rather than a budget that appropriates only the General Fund, the budget for maternal and child health services already includes federal funds and state General and Special funds in a complementary package of resources.

Independent Compliance review. The Vermont Health Department tracks its expenditures attributable to the Maternal and Child Health Block Grant. Prior to drawing funds or filing financial status reports, however, the data is independently reviewed by the Agency of Human Services (AHS). Cash draws are performed by AHS rather than the Health Department. As part of their review of the financial data, AHS also reviews compliance with certain of the grant financial requirements, specifically including the maintenance of effort requirement and the non-federal match. The quarterly calculations of the allowable claim by AHS, like the calculations of the Health Department, deducts one quarter's share of the maintenance of effort amount from our allowable charges prior to determining the cash draw for the quarter. AHS also determines that the needed non-federal share is available for each quarter. Once each quarter, AHS and the Health Department formally review the allowable federal claim after making adjustment for these factors. In this way, AHS assures that the Health Department has an independent review of our claims for federal funds.

30%-30% Requirement. The Health Department calculates the amount expended on each category. For FFY 2004, 45% of expenditures was made in Component B and 45% was made for Children with Special Health Care Needs.

Administration costs. Administrative costs are defined in the same terms that they were defined in 1989: administrative costs are the extra-departmental costs that are allocated to the Health Department and to the programs within the Health Department. These costs are that component of the allocated costs that are attributable to the support services of payroll, buildings, etc. The definition of "administration" costs does not include costs such as the policy direction activities of the Health Commissioner, etc. The administrative costs of the Maternal and Child Health Block Grant can be readily determined by analysis of the allocated costs, and these costs are tracked on a quarterly basis

to ensure that there is no increase in the costs that would exceed the allowable maximum. Administrative costs for FFY2002 were 2.2% of total costs.

Maintenance of effort. [Sec. 505(a)(4)] The maintenance of effort amount for Vermont, based on the amount of unmatched State expenditures reported in 1989, is $167,093. We deduct one quarter of the maintenance of effort amount from our allowable claims each quarter. Quarterly reductions of our allowable costs are more consistent with federal cash management directives than an end-of-year adjustment.

Special projects. [Sec.505(a)(5)(C)(i)] There is continuation funding for the Vermont Regional Perinatal Program, which was a special project that was funded by Title V prior to 1981. The funding for the program is $52,656.

Consolidated health programs. [Sec. 505(a)(5)(B)] Funds are used to support certain programs that were initiated under the provisions of the consolidated health programs, as defined in Section 501(b)(1). MCH Block Grant funds are used to support the Regional Genetics Program, which was initiated under a section 1101 grant prior to 1981, and is referred to as a consolidated health program in Sec 501(b)(1)(C). The Regional Genetics grant is $140,056. MCH Block Grant funds are also used to support the adolescent pregnancy program at the Addison County Parent Child Center, which was initiated under a Title VI grant prior to 1981, and is referred to as a consolidated health program in Sec. 501(b)(1)(D). The Addison County Parent Child Center grant is $32,820.

Other Federal funds. The other Federal funds used to support MCH-related goals are listed in Form 2 and 4. There is no significant change in the type or total amounts of other Federal funds. As noted above, this has not been changed to include Mental Health expenditures.

Source of State matching funds. The State match consists entirely of cash payments of State General funds or State Special funds (e.g., tobacco settlement funds, foundation grants, etc). The State match is exclusively from non-federal funds. These non-federal funds are appropriated as described above and the use of these non-federal funds is monitored by the Agency of Human Services as well as the Health Department, as noted above.

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.